

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0912

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Raymond C. Allen.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

32 years

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 30 in 1939

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Md. 21st Dist. Pa.

(Town, county, and state)

10. Usual occupation

Labour

11. Industry or business

Saw mill

12. Name

Raymond C. Allen

13. Birthplace

Md. 21st Dist. Va.

14. Maiden name

Jeanie Barnes

15. Birthplace

Md. 21st Dist. Pa.

16. Informant

John C. Allen

Address

Montgomery, Md. 21st Dist. Balt. 20

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Sept 4-48

(month) (day) (year)

Cemetery or crematory

Washington Park

Location

Md. 21st Dist. Connally

18. Funeral director

John C. Connally

Address

418 Eastern Ave.

19. (Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City

Etc.

Street

Bldg.

Floor

Appt.

Unit

Room

Suite

Apt.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948 at 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death

Drowning accidental

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident suicide or homicide

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Beach

Means of injury drowning

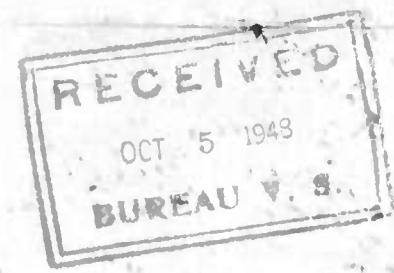
Injured at work

Signature D. McBaronie M.D.

or other

Address 418 East 2nd Street

Registrar Date signed Sept 4 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09125

30

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Balto

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Ogden Convalescent Home

How long in hospital or institution?

3. (a) FULL NAME

John A. Armour

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Maria L. Armour

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec 5th 1853

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Manchester N.H.

(Town, county, and state)

10. Usual occupation.

Marble Cutter

11. Industry or business

Own Business

MOTHER FATHER

12. Name

William Armour

13. Birthplace

Scotland

14. Maiden name

Isabelle Drury

15. Birthplace

Scotland

16. Informant

Mrs Isabelle A. Schroeder

Address

209 Glenmore Ave

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9/24/48
(month) (day) (year)

Cemetery or crematory

Lorraine

Location

Balto Co. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19. (Date recd by registrar)

9/23/48

19

A. W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Balto

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Edmondson Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 21st

1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1st 1948 to Sept 21st 1948and that I last saw him alive on Sept 21st 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Generalized Arterio

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leech Estokey

M. D. or other

Address

Balto

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09126
35

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town PARKTON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ANNA MAY BACON

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWEDROBERT S. BACON

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

years

August 19. 1864

8. AGE:

Years

Months

Days

If less than one day

84012

hrs.

min.

9. Birthplace BALTIMORE Co

(Town, county, and state)

10. Usual occupation

AT HOME

11. Industry or business

FATHER 12. Name HARRISON ALMOND13. Birthplace BALTIMORE CoMOTHER 14. Maiden name ELIZABETH HYRES15. Birthplace HARFORD Co16. Informant Mrs. Louis D. MarshallAddress Parkton, Md17. Burial Burial Date thereof Sept 4-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory VERNONLocation WHITE HALL - RFD18. Funeral director Howard S. MarklineAddress White Hall, Md19. Sept. 1, 1948 Mrs. Howard S. Markline
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M.D. County BALTIMORECity or town Parkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

10:30 A.M. to Sept. 1 1948and that I last saw her alive on Sept. 1 1948

Immediate cause of death

Chronic hypochondriasis

DURATION

Due to

Due to

Other conditions Hypertension
Arterio - sclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

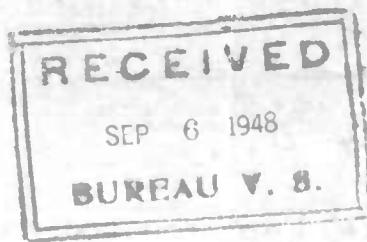
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. M. France M. D. or otherAddress Parkton, Md. Date signed 9/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

09127

44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 177 days
Hospitai, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution?..... 177 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 1308 N. Mount St.
(If rural, give LOCATION)
2.(a) If veteran, name war..... WW-1

3. (a) FULL NAME

EDWARD BROWN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	married

8. (b) Name of husband or wife..... Anne Brown
B.(c) If alive, give age..... 53 years

T. Birth date of deceased (mo. day, yr.)..... January 31, 1897

8. AGE: Year	Months	Days	If less than one day
51	7	10	hrs. min.

9. Birthplace..... Prince George Co., Va.
(Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business

MOTHER FATHER
12. Name..... Benjamin Brown
13. Birthplace..... Virginia

14. Maiden name..... Nellie Leslie
15. Birthplace..... Virginia

16. Informant..... Clinical Records, Vets. Adm. Hosp.
Address..... Fort Howard, Md.

17. Burial..... Date thereof..... Sept. 15, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Baltimore National Cemetery
Location..... Baltimore City

18. Funeral director..... George G. Kelson
Address..... 1303 Pressman Street

19. Sept. 14, 1948
(Date rec'd by registrar)

3. (b) Social Security Number

217-07-1662

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 11, 1948, at 2:00P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
March 18, 1948, to Sept. 11, 1948.

and that I last saw him alive on September 11, 1948.
Immediate cause of death..... TUBERCULOSIS, PULMONARY
CHRONIC FIBROID, FAR ADVANCED,
ACTIVE.

DURATION
Approx. 1 year.

Due to.....

Due to.....

Other conditions..... None
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... P. DOENGES, M.D. M.D. or other

Address..... VAH Ft. Howard, Md. Date signed..... 9-12-48

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09128

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balt.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Lizzie Campbell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

B. (b) Name of husband or wife

John Campbell

7. Birth date of deceased (mo., day, yr.)

July 28 - 1878

8. (c) If alive, give age years

8. AGE:

Years
70Months
7Days
0If less than one day
hrs. min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

George Getman

MOTHER FATHER

12. Name

Germany

13. Birthplace

Unknown

14. Maiden name

Germany

15. Birthplace

Germany

16. Informant

Mrs. Christina St. Albert

Address

522 Slover Ave.

17. Burial

Date thereof Oct. 1 - 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Rd.

18. Funeral director

John G. Connally

Address

418 Eastern Ave. Baltimore

19. Sept. 29 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Baltimore

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 522 Slover Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 28 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1948, 10 Sept. 1948, 1948 and that I last saw her alive on Sept. 27, 1948

Immediate cause of death

Cerebral thrombosis &

hemiplegia

myocarditis

Due to Hypertension

DURATION

1 week

5 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell Hornung M. D. or other

467 Eastern Ave. Baltimore Date signed Sept. 29 1948

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09129

CERTIFICATE OF DEATH

Reg. Dist. No. 97

38

1. PLACE OF DEATH:

Balto.

County.....

Anneslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

812 Regester Ave.

How long in hospital or institution?

3. (a) FULL NAME

EMMA BLANCHE CANNADAY

3. (b) Social Security Number

no

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female white widow

6.(b) Name of husband or wife..... Richard F., Cannaday

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1865

8. AGE: Years Months Days If less than one day
82 11 27 hrs. min.

9. Birthplace..... Floyd Co., Va.

(Town, county, and state)

Housewife

10. Usual occupation.....

11. Industry or business..... Robert Huff

12. Name..... Robert Huff

13. Birthplace..... Va.

14. Maiden name..... Mary Kefauver

15. Birthplace..... Va.

16. Informant..... Dr. R. G. Cannaday

Address..... 121 E. 60th St., New York City, N.Y.

17. Burial Date thereof..... 9/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Druid Ridge Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Baltimore, Md.

19. Date rec'd by registrar..... Sept 3 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

State.....

County.....

Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

102 W. Oakdale Rd.

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 1, 1948 at 1:45p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/14 1943 to 9/1 1948

and that I last saw her alive on 8/31 1948

Immediate cause of death.....

DURATION

Unknown

Unknown

Unknown

Due to..... Arterio sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Data of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Charles R. Goddard

M. D. or other

Address..... 2923 St Paul St. Date signed..... 9/2/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09130

44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Balto

City or town.....

Middle River

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

527 Compass Rd

How long in hospital or institution?.....

3. (a) FULL NAME

Grover H. Carries

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.

W.

married

6.(b) Name of husband or wife.....

Ida (Leffman)

65

years

7. Birth date of
deceased (mo., day, yr.)

Jan - 20 1885

6.(c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace.....

North Carolina

(Town, county, and state)

10. Usual occupation.....

Janitor

11. Industry or business

Glenn & Martin Co.

FATHER

Albert Carrico

MOTHER

13. Birthplace

Virginia

14. Maiden name.....

Caroline Higgins

15. Birthplace

Virginia

16. Informant.....

Mrs. Ida Carrico

Address

527 Compass Rd

17. Burial

Date thereof Sept. 7-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Oak Grove

Location.....

Belair Md.

18. Funeral director.....

John S. Connally

Address

48 Eastern Ave

19. Seat

6 - 19 X8

(Date rec'd by registrar)

John S. Connally
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Balto

City or town.....

Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

527 Compass Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

9/5/48

19.....

at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Stomach ulcer

DURATION

Due to.....

Hypoglycemia

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

89131

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore

City or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred

How long in hospital or Institution?

3. (a) FULL NAME

Harmon A. Clagett

3. (b) Social Security Number

4. Sex Male | 5. Color or race white | 6. (a) Single, married, widowed, or divorced Widower

B. (b) Name of husband or wife Lemma Clagett

Deceased

7. Birth date of Deceased (mo., day, yr.) Nov - 4 - 1871

8. AGE: Years Months Days If less than one day

76 10 14 hrs. min.

9. Birthplace Baltimore County Md

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Adam Clagett

13. Birthplace Balt. Co. Maryland

14. Maiden name Kilhor

15. Birthplace Balt. Co. Md

16. Informant Carrie Lerosa Frank

Address Randallstown Md

17. Burial Date thereof Sept 20, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Family

Location Harrisonville Maryland

18. Funeral director Franklin H. Newell

Address Pikesville Maryland

19. 9/19/1948 Tom E. Martin

(Date rec'd by registrar)

1948 Tom E. Martin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Liberty Road

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1848 to Sept 18, 1948 and that I last saw him alive on Sept 17, 1948

Immediate cause of death Cardiovascular Disease ?

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Tom E. Martin

M. D. or other

Address Randallstown

Date signed 9/19/48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

09132

CERTIFICATE OF DEATH

4

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Balto.

City or town.....

Chase.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Burd River Beach Rd.

How long in hospital or institution?

3. (a) FULL NAME

Virginia Mae Clarke.

3. (b) Social Security Number

4. Sex

5. Color of eyes

6. (a) Single, married, widowed, or divorced

Lem. White. Married
Nm. to Clark.

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age 39 years

Nov 8/1912

8. AGE:

Years

Months

Days

If less than one day

35

10

19

hrs.

min.

9. Birthplace

Glenside Md.

(Town, county, and state)

Home

10. Usual occupation

11. Industry or business

Joseph H. Nagle.

12. Name

Glenside Md.

13. Birthplace

Marie M. Mulligan

14. Maiden name

Matthew E. S. V.

15. Birthplace

Mrs. C. Clark (Husband)

16. Informant

Address

Aerial

(Burial, cremation, or removal which?)

Date thereof Sept. 30 - 48

(month) (day) (year)

Cemetery or crematory

Chase 2nd.

Location

John G. Connally

18. Funeral director

418 Eastern Ave. E.

Address

Sept. 29 - 1948

(Date rec'd by registrar)

John G. Connally

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Balto.

City or town.....

Bx 208 Chase

Street No.....

Burd River Beach.

(If rural, give LOCATION)

2. (a) If veteran, name war.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 27 1948 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

19...

and that I last saw him alive on 19...

19...

Immediate cause of death

Fracture base skull

DURATION

Fracture cervical vertebra

D.

Fracture rt. lower fibia

D.

Crushed left clavicle

D.

Contusion & bruise torso

D.

Other condition

D.

Contusion & bruise legs

D.

Left thigh fracture (within 8 months of death)

D.

Left leg crushed

D.

Medically impossible

D.

Death op.

D.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide. Accident Date of 9/27/48

Where did injury occur? Chase Balto. County (City or town) State

Injured at home, farm, industry, public place (where?) Public place

Means of injury Automobile. Injured at work? No

Machinery. Date of 9/27/48

Deputy Sheriff Date of 9/27/48

M. D. or other

Address 100 W. Randolph St. Date of 9/27/48

Balto Co. Maryland Date of 9/27/48

M. D. or other

OCT 1 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09133

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH: Baltimore
 County
 City or townCatonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months.

Hospital, Institution, or street address where death occurred:

Rev. Opitz Nursing Home

How long in hospital or institution?

(MAMIE) Mary Sarah Clayton3. (a) FULL NAME Mary Sarah Clayton

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed
------------------	---------------------------	--

6.(b) Name of husband or wife Harry Clayton6.(c) If alive, give age years7. Birth date of deceased (mo. day, yr.) August 8, 1859

8. AGE: Years 89	Months 1	Days 18	If less than one day hrs. min.
---------------------	-------------	------------	--

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Frederick C. Lindenberg	13. Birthplace Germany
-------------------------------------	---------------------------

14. Maiden name Not Known	15. Birthplace Not Known
------------------------------	-----------------------------

16. Informant Mrs. Esther L. Dowell
Address 508 E. 39th St.,17. Burial 9-28-1948
(Burial, cremation, or removal, Which?) Date thereof. (month) (day) (year)Cemetery or crematory Mt. Olivet
Location Baltimore, Md.18. Funeral director G. Howard Strong
Address 3207 W. North Ave.19. Sept. 27 1948 J. W. Henning
(Date record by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 508 E. 39th St.,
(If rural, give LOCATION)2.(a) If veteran, name war ✓3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948 at 3:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Sept 1948, to 26 Sept 1948, and that I last saw her alive on 26 Sept 1948.Immediate cause of death Cardiac failure, acute
Duration 1 dayDue to Hypertension and arteriosclerosis
cardiovascular disease with
? myocardial degenerationDue to hypertension and arteriosclerosis
cardiovascular disease with
? myocardial degeneration

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emil W. Henning Jr. M.D.
M. D. or otherAddress 4580 Edmond Ave Date signed 27 Sept 48

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

1572

Reg. Dist. No.

31
05134

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 (a) County Baltimore
 (b) City or town Daniels
 (c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days) 12 hrs

3 (a) FULL NAME Larry Collins

3 (b) If veteran, name war A 3 (c) Social Security No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife _____

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/26/48

8. AGE: Years _____ Months _____ Days _____ If less than one day
 15 hr. _____ min.

9. Birthplace Daniels, Baltimore Co., Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Oscar Collins

13. Birthplace Virginia

14. Maiden Name Mary Hattie Roberts

15. Birthplace Tenn

16. (a) Informant Hattie Marie Collins
 (b) Address Daniels

17. (a) Burial (b) Date thereof 9/27/48
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory Brook Shepherd
 Location Howard Co

18. (a) Funeral director Parey
 (b) Address Daniels

19. (a) 10/27/48 (b) Dr. E. Martin
 (Date rec'd by registrar) (Date signed) Dr. E. Martin
 Registrar

2. HOME (USUAL RESIDENCE) OF DECEASED:
 (a) State Md (b) County Baltimore
 (c) City or town Daniels
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. _____
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Larry Collins (TWIN #2)

MEDICAL CERTIFICATION

20. Date of death Sept 27, 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26/1948 to 9/27/1948 and that I last saw him alive on 9/26/1948.

Immediate cause of death Cyanosis at birth with poor respiration

Due to Congenital heart dis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
 (Specify type of place)

(e) Means of injury _____

23. Signature Dr. E. Martin
 M. D. or other _____
 Address Randallstown
 Date signed 9/27/48



M
I
T

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09135
bc
12465
xx

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore

City or town Ft. Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Vets Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 3 days

3. (a) FULL NAME

EDWARD COOK

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 7-27-92
8. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
56	1	5	hrs. min.

9. Birthplace Middlesex, Virginia
(Town, county, and state)

10. Usual occupation Iceman

11. Industry or business

12. Name Asie Cook

13. Birthplace Middlesex, Va.

14. Maiden name Unknown

15. Birthplace Unknown

16. Intertant Clinical Records, Vets. Adm. Hospital
Fort Howard, Maryland
Address

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 9/7/48
(month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Charles R. Law

Address 802 Madison Ave. Balt., Md.

19. (Date rec'd by registrar) 9/5 19 XW Heddell
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Pierce St.
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 30 1948, to September 2 1948,

and that I last saw him alive on September 2 1948.

Immediate cause of death

Cirrhosis of liver

DUE TO:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH H.C. MANAUGH, M.D.C.H.F.P.H.D. SERVICES

Address VAH, Fort Howard, Md. Date signed 9-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09136

CERTIFICATE OF DEATH

Reg. Dist. No. 42?

1. PLACE OF DEATH:

County

Balto

City or town

13 Below Westport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3715 Annapolis Rd

How long in hospital or institution?

3. (a) FULL NAME

George M. Cord Sr

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Annie E. Cord

7. Birth date of deceased (mo., day, yr.)

April 4th 1861

6. (c) If alive, give age

years

8. AGE:

Years
87Months
5Days
6

If less than one day

hrs.

min.

9. Birthplace

N.C.

(Town, county, and state)

at Home

10. Usual occupation

George Cord

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Katherine Deansstadt

Address 3715 Annapolis Rd - Balto. Co.

17. Burial

Date thereof 9/9/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Westview

Location

Balto. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St

19. (Date rec'd by registrar)

9/8 1948

(Date rec'd by registrar)

R.W. Hedrich

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Balto

City or town

Below Westport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3715 Annapolis Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 6th

1948, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sep 1, 1948, to Sept 6, 1948

and that I last saw him alive on

Sept 6, 1948

Immediate cause of death

Acute Cardiac Failure 1 day

DURATION

Due to

Myocardial Failure

Cardiac decompensation [10/22/48 a/c]

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis J. Glouby M.D. or other

Address: 86 Washington St. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51e 09144

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 36 days

3. (a) FULL NAME

ISAAC H. DAVIS4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife Single

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-068. AGE: Years 42 Months 3 Days 11 If less than one day hrs. min.9. Birthplace Morehead City, N.C.
(Town, county, and state)10. Usual occupation Press Operator

11. Industry or business

MOTHER FATHER 12. Name Amos Davis13. Birthplace North Carolina14. Maiden name Eula Henderson15. Birthplace North Carolina16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland17. BURIAL Date thereof 9/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PrivateLocation Morehead City, N.C.18. Funeral director Charles LawAddress 802 Madison Ave. Balto. Md.19. Sept. 11/1948 William M. Kelly Jr.
(Date rec'd by registrar) Watson & Parker, Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 2229 Division Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW II

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948 4:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1948 to Sept. 10 1948 and that I last saw him alive on September 10 1948.

Immediate cause of death

Pericardial Tamponade

DURATION

2 days

Due to Metastatic tumor in pericardium

Due to

Other conditions Tumor of lung with metastases

(Include pregnancy within 3 months of death)

3 mos.

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Russell Brandon, M.D.
Address VAH FT. Howard, Md. M. D. or otherDate signed 9-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09138
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Pikesville-8, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Florence Davis

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... John Joseph Davis

7. Birth date of deceased (m.e., day, yr.)..... Nov. 19, 1866

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
81	9	24	hrs. min.

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Home duties

11. Industry or business

12. Name..... Arthur Chenoweth

13. Birthplace..... Md.

14. Maiden name..... Harriet Jones

15. Birthplace..... Md.

16. Informant..... Harriet J. Davis

Address..... Pikesville, Md.

17. Burial..... Date thereof..... Sept. 15 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Druid Ridge

Location..... Pikesville, Md.

18. Funeral director..... Frank H. Newell

Address..... Pikesville-8, Md.

19. 9-15-48
(Date rec'd by registrar)

E-E Nichols

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Pikesville-8, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Church Lane

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 13, 1948, at 2- P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 25, 1947, to Sept. 13, 1948,

and that I last saw her..... alive on Sept. 10, 1948.

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to..... Chronic Myocarditis

2 yrs.

Due to..... Arterio Sclerosis

?

Other conditions..... Senility

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

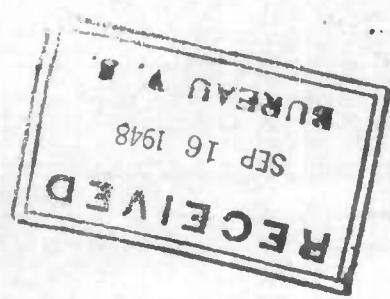
Injured at work?

23. SIGNATURE..... E-E Nichols MD

M. D. or other

Address..... Pikesville-8, Md.

Date signed..... 9-15-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bw

09139

CERTIFICATE OF DEATH

Reg. Dist. No.

30

M
the correct age

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

House on the Pines, 16 Huntingdon

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

W.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation

Salesman C. & P. Telephone Co

11. Industry or business

Robert Duncan

12. Name

Indiana

13. Birthplace

Margaret E. Mulroy

14. Maiden name

Ireland

15. Birthplace

Miss Mary E. Duncan

16. Informant

509 Old Orchard Rd

Address

17. Burial

Oct. 1/48

(Burial, cremation, or removal. Which?)

Date thereof.

(month)

(day)

(year)

Cemetery or crematory

Lorraine Pk.

Location

Woodlawn Cem.

18. Funeral director

Harry H. Miller

Address

4101 Edmondson Ave.

19. (Date rec'd by registrar)

9/30/48 D.W. Hedrick

19.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Old Orchard Rd. Twn.

Heights

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27/48 19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 13 1948 to Sept. 27 1948

and that I last saw h. m. alive on Sept. 27 1948

Immediate cause of death

Heart Failure

DURATION

3 wks

Due to Myocardial Dilation

Due to Coronary Occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of injury

Injured at work?

3. SIGNATURE

H. Wasserman

M. D. or other

Address 1501 Eutaw Place Date signed 9-29-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09140

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 6 days

3. (a) FULL NAME

ROBERT E. ELLENBERGER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Myrtle Ellenberger

6. (c) If alive, give age 54 years

7. Birth date of deceased (mo. day, yr.)

October 12, 1886

8. AGE:	Years	Months	Days	If less than one day
	61	10	25	hrs. min.

9. Birthplace Fair Hope, Pa. (Town, county, and state)

10. Usual occupation Lineman

11. Industry or business Crown Cork & Seal Co.

12. Name Michael Ellenberger

13. Birthplace Pa.

14. Maiden name Manda Philson

15. Birthplace Pa.

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof 9/11/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Park Cemetery

Location Woodlawn, Md.

18. Funeral director Wm. J. Tickner

Address North & Penna. Aves. Balto. Md.

19. Date rec'd by registrar 9/8/48

(Date rec'd by registrar) 10 A.M. R.W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1115 Poplar Grove St.

(If rural, give LOCATION)

2.(a) Is veteran, name war WW-1

3. (b) Social Security Number

u 220-09-6330

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1948 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1948 to September 7 1948 and that I last saw him alive on September 7 1948.

Immediate cause of death

CEREBRAL VASCULAR ACCIDENT

Due to Arteriosclerosis

Due to

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury acn Injured at work?

23. SIGNATURE H.C. MANAUGH, M.D., C.H.E., PRO. SER. M. D. or other

Address VAH Ft. Howard, Md. Date signed 9-7-48

(1949 Revision of Standard Certificate)
CERTIFICATE OF DEATH

Form approved.
Budget Bureau No. 18-R375.

BIRTH NO.

STATE OF

Maryland

STATE FILE NO. *AB*
05141

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN Catonsville

c. LENGTH OF STAY (in this place)

d. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION The Rev. A. Opitz Home

3. NAME OF DECEASED

(Type or Print)

MARGARET

a. (First) b. (Middle)

B.

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

married

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

no

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

MEDICAL CERTIFICATION

Chr. Myocarditis -

INTERVAL BETWEEN ONSET AND DEATH

*1 yr.**Parenchyma of Brain**2 yrs*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

No

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP)

(COUNTY)

(STATE)

21d. TIME OF INJURY

(Month)

(Day)

(Year)

(Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 1, 1948*, to *Sept 30, 1948*, that I last saw the deceased alive on *Aug 30, 1948*, and that death occurred at *6 P m.*, from the causes and on the date stated above.

23a. SIGNATURE

(Degree or title)

Rev. A. Opitz

23b. ADDRESS

Baltimore

23c. DATE SIGNED

*10-1-48*24a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

24b. DATE

10/2/48

24c. NAME OF CEMETERY OR CREMATORIUM

Methodist Ch. Cem.

24d. LOCATION (City, town, or county)

(State)

*Fort Ashby**W. Va.*

DATE REC'D BY LOCAL REG.

10/11/48

REGISTRAR'S SIGNATURE

a. w. Hedrick

25. FUNERAL DIRECTOR

WILLIAM J. TICKNER & SONS

ADDRESS

Baltimore, Md.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09142

159

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County.....*Baltimore*
 City or town.....*Owings Mills*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*2 hrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Ernest Fisher, Jr.

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)*Sept. 27, 1948*

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

2 hrs.

min.

9. Birthplace.....*Owings Mills, Md.*
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....*Charles Ernest Fisher*13. Birthplace.....*Owings Mills, Md.*14. Maiden name.....*Dolores Moats*15. Birthplace.....*Owings Mills, Md.*16. Informant.....*Dolores Moats*Address.....*Owings Mills, Md.*17. Burial.....*Burial* Date thereof.....*Sept. 28, 1948*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or Cemetery.....*Riverside*Location.....*Riverside, Md.*18. Funeral director.....*William Berryman & Sons*Address.....*Riverside, Md.*19. 9-28 1948
(Date rec'd by registrar)Mary B. Eline
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.* County.....*Baltimore*City or town.....*Owings Mills*
(If outside city or town limits, write RURAL and give nearest town)Street No.....*Glenbrook Ave.*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Sept. 27 1948* at *7:30 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
9/27 1948 to *9/27 1948*and that I last saw him.....alive on.....*9/27 1948*

Immediate cause of death.....

Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....*Martin E. Sorrel*

M. D. or other

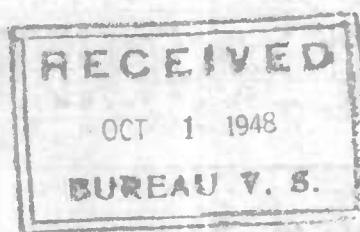
Address.....*Riverside, Md.* Date signed.....*9/27/48*

RECEIVED BY THE FEDERAL BUREAU OF INVESTIGATION

U. S. DEPARTMENT OF JUSTICE

1000 23rd Street, N.W., Washington, D.C.

AMERICAN JACKET



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09143
93d

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH:

County.....

Balto.

City or town.....

Sparky (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Sally Cole

Fowle

4. Sex

5. Color or race

8.(a) Single, married, widowed, or divorced

Female white Widowed

8.(b) Name of husband or wife.....

Wilmer Fowle

8.(c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)

Mar. 31 1910

8. AGE: Years Months Days If less than one day

78 5 9 hrs. min.

9. Birthplace.....

Balto Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Alfred Cole

12. Name.....

Balto Co. Md.

13. Birthplace

Dorcas Brooks

14. Maiden name.....

Balto Co. Md

15. Birthplace

Geo. B. Cole

16. Informant.....

2927 Woodlawn Ave Balto

Address

Burial

Date thereof Sept. 12 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Black Rock

Location

Butler, Balto Co. Md

18. Funeral director.....

Sanderson M. Brooks

Address

Sparky, Md.

Sept. 11, 1948

Wilmer C. Ensor

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Balto

City or town.....

Sparky (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Western

Run Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept 9 1948 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 36 to Sept. 9 1948

and that I last saw her alive on Sept. 8 1948

Immediate cause of death.....

Myocarditis Chronic decompensata 2 yrs

Due to.....

Hypertension

Due to.....

Arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. 4

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Date signed 9-9-48



STATE OF MARYLAND—CERTIFICATE OF DEATH

09144

1. PLACE OF DEATH

County Baltimore
 Village or City Sutherland

Registration Dist. No. 37St. Ward Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

Betty Katherine Fox(a) Residence: No. Sutherland

(Usual place of abode)

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
-----------------	---------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

Nov. 30, 1921

7. AGE <u>26</u>	Years	Months <u>9</u>	Days <u>15</u>	If LESS than 1 day, _____ hrs. or _____ min.
---------------------	-------	--------------------	-------------------	--

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	None
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	<u> </u>
10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)
(State or country) Chicago, Ill.13. NAME Mary B. Fox14. BIRTHPLACE (city or town)
(State or country) Baltimore, Md.15. MAIDEN NAME Florence Hilgartner16. BIRTHPLACE (city or town)
(State or country) Towson, Md.17. INFORMANT M. B. Fox
(Address) Sutherland, Md.18. BURIAL, CREMATION, OR REMOVAL
Place Greenmount Cem., Balt. Date Sept. 17, 194819. UNDERTAKER Sanderson & Brothers
(Address) Sparks, Md.20. FILED 9-15-, 1948 Wilmer C. Ensor
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Sept.15(Month) 1948 (Year)

22. I HEREBY CERTIFY. That I attended deceased from

July, 1948, to Sept., 1948.
I last saw her alive on 16 Sept., 1948; death is said
to have occurred on the date stated above, et. 5 A.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:encephalitis lethargica Date of onset June 18

Other Contributory Causes of Importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19_____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) L. Charles W. Rice M. D.(Address) 6721 York Rd. Baltimore Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Pneumonia	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09145

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County *Baltimore*City or town *Dundalk*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

2059 Detroit Avenue

How long in hospital or institution?

3. (a) FULL NAME

William Gerhart

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*m.**w.**m.*6.(b) Name of husband or wife *Beatrice M. Gerhart*

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

April 22, 1900

8. AGE: Years

Months

Days

If less than one day

*48**4**29*

hrs.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual occupation *Blooming mill Roller*11. Industry or business *Pittsburgh Steel Co.*

FATHER

12. Name *William*

MOTHER

13. Birthplace *Md.*14. Maiden name *Bertha*15. Birthplace *Pennsylvania*16. Informant *Beatrice M. Gerhart*

Address

2059 Detroit Ave., Dundalk, Md.

17. Burial

Date thereof *Sept. 23, 1948*
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Oak Lawn

Location

7225 Eastern Blvd.

18. Funeral director

Roland L. Fischer

Address

2112 Dundalk Ave., Dundalk

19. Date rec'd by registrar

Sept. 23, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md.

County

Baltimore

City or town

Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2059

Detroit Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 20* 1948 at *8:15 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

to

10.

and that I last saw him alive on

19.

Immediate cause of death

Coronary Occlusion DURATION *5 min.*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date ofWhere did injury occur? *Home* (City or town) (County) (State)

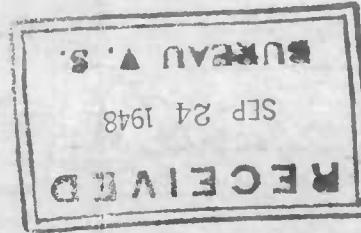
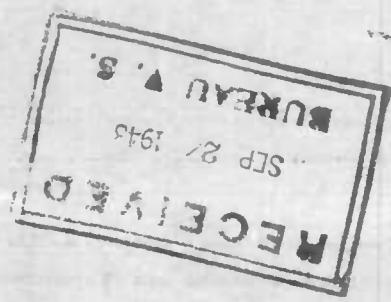
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. B. Davis, M.D. Date of birth *Aug. 20, 1900*
Address *2112 Dundalk Ave., Dundalk* Date signed *Sept. 23, 1948*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

69146

CERTIFICATE OF DEATH

Reg. Dist. No. 30

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

9 Dungarrie Rd.

Stay in hospital or inst. (yrs., or mos., or days)

10 yrs.

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Clyde E. Good4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Euphemia Good7. Birth date of deceased (mo., day, yr.) May 9, 1904 8. (c) If alive, give age _____ years8. AGE: Years 44 Months 3 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace N. J. (Town, county, and state)10. Usual occupation Manager11. Industry or business Personal Finance Co.12. Name Robert H. Good13. Birthplace -----14. Maiden name Mae Edridge15. Birthplace -----16. Informant Mrs. Euphemia Good,
Address 9 Dungarrie Rd. Catonsville, Md.Burial Sept. 7/48.17. (Burial, cremation, or removal. Which?) Woodlawn Date thereof (month) (day) (year)Cemetery or crematory WoodlawnLocation Woodlawn, Md.18. Funeral director Harry A. LutzkeAddress 4101 Edmondson Ave.19. 9-7 19 48 J.E. Harry
(Date rec'd by registrar) Registrant

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville Ward No. -----Street No. 9 Dungarrie Rd. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1948, at 4:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1946, to Sept. 4 1948, and that I last saw him alive on August 29 1948.

Immediate cause of death

Acute Coronary Thrombosis

DURATION

1 hr.Due to Coronary Thrombosis and
Arteriosclerosis

4 yrs (?)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline
the cause to which
death should be
charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE William K. Gallagher, M.D. M. D. or otherAddress Catonsville 28, Md. Date signed 9-4-48

V9-A15 T



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09147
38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 yrs.
 Hospital, Institution, or street address where death occurred:
 Presbyterian
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Md. County..... Baltimore,
 City or town..... Towson,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Presbyterian Home
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Lulu Lee Gordon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife..... Harold L. Gordon

7. Birth date of deceased (mo., day, yr.)..... April 23, 1866

8. AGE: Years..... 82 Months..... 4 Days..... 29 If less than one day
..... hrs. min.9. Birthplace..... Louisville, Ky.
(Town, county, and state)

10. Usual occupation..... none

11. Industry or business..... Oscar Board

12. Name..... Brendenberg, Ky.

13. Birthplace..... Elizabeth E. Clark

14. Maiden name..... Md.

15. Birthplace..... Mrs. T. E. Elliott Supt.

16. Informant..... Presbyterian Home Towson, Md.

Address..... Butial Date thereof..... 9/25/1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Druid Ridge

Location..... Pikesville, Md.

18. Funeral director..... John O. Mitchell Sons Inc.

Address..... 1900 Eutaw Place Balt. Md.

19. Sept 24, 1948 W. Carroll Van Horne
(Date rec'd by registrar) Registrar**MEDICAL CERTIFICATION**

20. DATE OF DEATH..... Sept. 22, 1948 at 5 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1948, to Sept 22, 1948, and that I last saw her alive on Sept 22, 1948.

Immediate cause of death.....

Due to..... Hypertension

Due to..... Anterior Sclerosis & Hypertension

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... H. Carroll Van Horne, M.D.

M. D. or other.....

Address..... Towson - 4 and Date signed..... 9/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09148
38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Baltimore
2900 Onyx Ave Parkville

(If outside city or town limits, write RURAL and give nearest town)

City or town
How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Edith Ross Green

4. Sex

F. W. Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Elmer R. Green

7. Birth date of deceased (mo., day, yr.)

Jan. 7, 1878

6. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

70

9

18

hrs.

min.

9. Birthplace

Ontario Canada

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Solomon Dawson

12. Name

Solomon Dawson

13. Birthplace

Canada

14. Maiden name

Mary Hannah Quack

15. Birthplace

Canada

16. Informant

Elmer R. Green

Address

2900 Onyx Ave. Parkville Md

17. Burial

Date thereof Sept 29/1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Jarrettsville

Location

Jarrettsville Md

18. Funeral director

Martin J. Kutz

Address

Jarrettsville Md

19. Date rec'd by registrar

Feb 26

1948

A. M. Baer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town 2900 Onyx Ave Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

—

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 25, 1948 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw h. alive on 19..... to 19.....

Immediate cause of death Right disease, vascular DURATION

coronary, with occlusion Sudden

Due to Arteriosclerosis

Unknown

Due to

Other conditions Hypertension 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

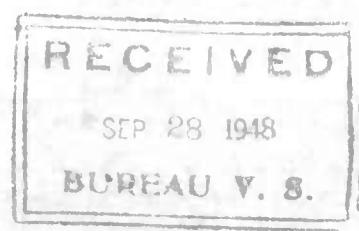
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Boiling Hudson MD D.M.E. M. D. or other

Address Towson Md Date signed Feb 26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09148
44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Baltimore

City or town

Colgate

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Robt Grum

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Married

6. (b) Name of husband or wife

Catherine Grum

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

June 29 1875

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

23

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation.

Butcher

11. Industry or business

Butcher

MOTHER FATHER

12. Name

John Grum

13. Birthplace

Germany

14. Maiden name

Dont know

15. Birthplace

Germany

16. Informant

Catherine Grum

Address

Box 426 Oriole Ave. Baltimore

17. Burial

Date thereof Oct 1-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Holy Redeemer Cemetery

Location

City

18. Funeral director

Leland Funeral Home

Address

2008 Orleans St

19. Date rec'd by registrar

10-1 1948 Butcher

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

Colgate

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Box 426 Oriole Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 28

1948

at 9:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1st

1948

to Sept. 28 1948

and that I last saw him alive on Sept. 28 1948

Immediate cause of death

Carcinoma of Bladder

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James H. White, M.D.

M. D. or other

42 Easton Ave

Date signed

Balitmore 21, MD

Ellis
El
by
61

~~M~~ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *44**552* 09150

1. PLACE OF DEATH:

County

*Baltimore*City or town *Box 345, Chesaco Park #6 Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

32 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Karl Hajek

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Anna Hajek

6.(c) If alive, give age years

Feb. 14, 1885

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days It less than one day

63

9. Birthplace

(Town, county, and state)

Plauenburg, Hungary

10. Usual occupation

Machinist

11. Industry or business

Hajek

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address *Box 345 Chesaco Park #6 Md*

Burial

Date thereof *9-23-48*
(month) (day) (year)

Cemetery or crematory

Oaklawn

Location

Eastern Ave

18. Funeral director

Address *John P. Moran*

Sept. 20, 1948

A. W. Henrich

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

Box 345 Chesaco Park #6 Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 21, 1948, at 5 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*March 1, 1948, to Sept 21, 1948*and that I last saw him alive on *Sept 18, 1948*

Immediate cause of death

*Carcinoma*Due to *Carcinoma of rt.
Submaxillary gland*

Due to

Other conditions *chr. arteritis
empty sacra*

(Include pregnancy within 3 months of death)

Major findings of operations *Carcinoma of rt.
Submaxillary gland* Date of op. *March 1948*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE *Lewis J. Grunbaum* M. D. or otherAddress *722 No. Kenwood* Date signed *Sept 11, 1948*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47a

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 78 days

3. (a) FULL NAME

NEILSON M. HALL4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Divorced7. Birth date of deceased (mo., day, yr.) 2-25-93 8. (c) If alive, give age years8. AGE: Years 55 Months 6 Days 8 If less than one day hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name George Hall13. Birthplace Baltimore, Maryland14. Maiden name Elizabeth Orem15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial Burial Date thereof 9/7/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Rd., Balto. Md.18. Funeral director Howard W. Blight Jr.Address 9009 Haydn Road19. (Date rec'd by registrar) 9/7/48 R.W. Hedrick Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 132 Fawcett Street

(If rural, give LOCATION)

2. (a) If veteran, name war WW I

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948 at 4:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1948 to Sept. 3 1948 and that I last saw him alive on September 3 1948.Immediate cause of death METASTATIC CARCINOMA OF LUNGS, LIVER, KIDNEYS, AND BONE PRIMARYDue to XXX SITE UNKNOWN DURATION UNKNOWNDue to Other conditions (Include pregnancy within 3 months of death)Major findings of operations Date of op. Autopsy results Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of... Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury J. J. Rehmeyer Injured at work? 23. SIGNATURE OF PHYSICIAN J. J. Rehmeyer, M.D. M. D. or other Address Vah Ft. Howard, Md. Date signed 9-11-48

(1949 Revision of Standard Certificate)
CERTIFICATE OF DEATH

Form approved.
Budget Bureau No. 68-R375.

30152

BIRTH NO.		STATE OF		STATE FILE NO.	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)	
a. COUNTY Baltimore				a. STATE Maryland b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Catonsville-28		c. LENGTH OF STAY (in this place) 4 mos. 4 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Baltimore	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS (If rural, give location) 719 Northern Parkway			
3. NAME OF DECEASED (Type or Print) Mary		a. (First) Mary b. (Middle) V. c. (Last) Hardy		4. DATE OF DEATH (Month) (Day) (Year) September 29, 1948	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		8. DATE OF BIRTH June 4, 1868	
13. FATHER'S NAME John Ellis Jordan				9. AGE (In years last birthday) 80	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		IF UNDER 1 YEAR Months 3 Days 25 IF UNDER 24 HRS. Hours - Minutes -	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal pneumonia		17. INFORMANT Hospital records, Catonsville-28, Maryland	
		DUE TO (b) Central nervous system lues		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
		DUE TO (c) Hypertensive cardiovascular disease with generalized arteriosclerosis		indefinite	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				" "	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION -		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) Catonsville-28, Baltimore (COUNTY) Maryland (STATE) Maryland	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 25 , 1948 to September 29 , 1948, that I last saw the deceased alive on Sept. 29 , 1948, and that death occurred at 12:30 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE <i>Abraham Schneidmuhl, M.D.</i>		(Degree or title)		23b. ADDRESS Catonsville-28, Maryland 23c. DATE SIGNED 9-29-48	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/2/48		24c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery 24d. LOCATION (City, town, or county) Baltimore, Md. (State)	
DATE REC'D BY LOCAL REG. 9-30-48		REGISTRAR'S SIGNATURE <i>J.W. Helms</i>		25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC. NORTH AVE. & BROADWAY	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

69154
43

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Balto.
Kingsbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Frederick L.

7. Birth date of

deceased (mo., day, yr.)

March 20 1892

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

56

6

7

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Balto.

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. BURIAL.....

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date record by registrar.....

(Date record by registrar)

Date thereof.....
(month) (day) (year)

PARKWOOD CEMETERY.

3310 TAYLOR AVE

THE DIPPEN BROS

7110 BELAIR RD.

Sept 28 1948 Q. W. Hedden

(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

City or town.....

Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

21

McCormick Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-22-6860

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Sept 27 1948 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1942 to September 27 1948

and that I last saw her alive on 9 - 20 1948

Immediate cause of death.....

Metastatic CARCINOMA

Due to.....

CARCINOMA OF CERVIX
OF UTERUS

Due to.....

5 yrs.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... CARCINOMA OF CERVIX UTERI
(Dr. John J. ERWIN) Date of op. Sept 1943

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

John W. Hedden M.D. or other

Address..... 6331 Belair Rd - G Date signed 9/27/48

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09153
83a

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County BALTIMORECity or town CATONSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? APPROXIMATELY 1 MO.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED6. (b) Name of husband or wife late7. Birth date of deceased (mo., day, yr.) AUGUST 4, 1880 6. (c) If alive, give age years8. AGE: Years 68 Months 1 Days 1 If less than one day hrs. min.9. Birthplace VIRGINIA (Town, county, and state)10. Usual occupation UNEMPLOYED

11. Industry or business

12. Name PETER C. MYERS13. Birthplace VIRGINIA14. Maiden name VIRGINIA CRIDLER15. Birthplace MARYLAND16. Informant MRS. FRANK WALLAddress 3 WYNDCREST AVE17. BURIAL Date thereof SEPT 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NEW CATHEDRALLocation OLD FREDERICK RD18. Funeral director Henry H. WittekeAddress 4101 Elmondean Ave19. Date rec'd by registrar 9/8 1948

(Date received by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty BALTIMORECity or town CATONSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 WYNDCREST AVE

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MARY R HAUPT

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 5, 1948 at 245 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Sept. 4, 1948and that I last saw her alive on Sept. 4, 1948

Immediate cause of death

Cerebral HemorrhageDue to ObstructionDue to Obstruction

Due to

ObstructionObstruction

Other conditions

Obstruction

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D. Lutzenberger M. D. or otherAddress 71 Madison St. Bldg. 917 Date signed 9/7/48

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09155
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County **Baltimore**City or town **Woodlawn**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JEHU H. HAYNIE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Bessie

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

September 2, 1860

8. AGE:

Years **88**Months **0**Days **13**

If less than one day

hrs. min.

9. Birthplace

Northumberland Co. Virginia

(Town, county, and state)

10. Usual occupation

Salesman**J. R. Watkins Co.**

11. Industry or business

Jehu H. Haynie

MOTHER FATHER

12. Name.....

13. Birthplace

Virginia

14. Maiden name

Elizabeth

?

15. Birthplace

Virginia

16. Informant

Mrs. Bessie Johnston

Address

5202 Gwyndale Avenue

17. Removal

Date thereof **Sept. 17, 1948**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Roseland Cemetery

Location

Reedsville, Virginia

18. Funeral director

William Cook, Inc.

Address

1217 St. Paul Street19. Sept 17 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**

County

BaltimoreCity or town **Woodlawn**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **5202****Gwyndale Avenue**

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

- Sept. 14 th 1948

at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug. 13 th 1948 to **Sept. 14 1948**and that I last saw him/her alive on **Sept. 13 th 1948**.

Immediate cause of death

**[1] - Arterio - Sclerotic
Heart Disease**

DURATION

10 yrs.?

Due to

Due to

Other conditions

**Generalized Arterio -
Sclerosis**

(Include pregnancy within 3 months of death)

Major findings of operations

done

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold Chambers

M. D. or other

Address

4108 Liberty St.Date signed **9/16/48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

872

CERTIFICATE OF DEATH

Reg. Dist. No.

09156
33

1. PLACE OF DEATH:
Baltimore
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 17 years
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution?..... 17 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md. County..... Balto.
City or town..... Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Osborne Dunlap Heard.

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single		
6.(b) Name of husband or wife.....				
7. Birth date of deceased (mo., day, yr.) March 31, 1926				
8. AGE:	Years 22	Months 5	Days 6	If less than one day hrs. min.
9. Birthplace..... (Town, county, and state)	Baltimore, Md.			
10. Usual occupation..... None				
11. Industry or business				
12. Name..... Osborne O. Heard				
13. Birthplace..... Maryland				
14. Maiden name..... Mary Dunlap				
15. Birthplace..... Virginia				
16. Informant..... Hospital Records				
Address..... Rosewood St. Tr. School.				

17. Cremation Date thereof..... Sept 9 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... London Park

Location.....
Geo. M. Finch & Son

18. Funeral director.....
811 N. Wolfe St.

Address.....
G/S D.W. Hedden

19. (Date rec'd by registrar) 19..... 9/8 '48
Registrar..... Dr.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 7 1948, a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6, 1948, to Sept. 7, 1948, and that I last saw him alive on Sept. 7, 1948.

Immediate cause of death..... Bronchopneumonia

DURATION
4 days

Due to.....

Due to.....

Other conditions..... Grand mal epilepsy
Congenital spastic diplegia
(Include pregnancy within 8 months of death)
21 plus yrs.

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Md. Injured at work?..... Baltimore.

23. SIGNATURE..... Dr. B. John M.D.
M. D. or other

Address..... Rosewood St. Tr. School Date signed..... 9/7/48

MD.
BETCO.
Owings Mills

W.A. 81 Sept. 3

81 81 Sept. 3
81 81 Sept. 3

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09157
1312

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County... Baltimore

City or town... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... *Baltimore*City or town... Whitmarsh
(If outside city or town limits, write RURAL and give nearest town)

Street No... Box... 473

(If rural, give LOCATION)

2.(a) If veteran, name war... WW I

3. (a) FULL NAME

HARRY A. HELF, SR

4. Sex Male 5. Color of race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Freida Helf

7. Birth date of deceased (mo., day, yr.) June 11, 1898 6.(c) If alive, give age 48 years

8. AGE: Years Months Days If less than one day
50 3 2 hrs. min.9. Birthplace New York City, New York
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER 12. Name John Helf, dec.

13. Birthplace New York

14. Maiden name Christine Larenze

15. Birthplace New York

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof 9/16/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Howard Blight Howard H. Blight Jr.

Address 6009 Harford Road Baltimore, Md.

19. Sept 16 1948 Q 24 H. J. Qual
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

109-05-3391

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 29 1948 to Sept. 13 1948

and that I last saw him alive on Sept. 13 1948

Immediate cause of death

Chr. Nephritis

DURATION

Unknown

Due to Unknown

Due to

Other conditions Extreme hypertrophy of heart
with failure Due to: Chr. Nephritis Unknown
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H.C. MANAUGH, M.D. Chief Pro. Ser. M.D. or other

Address VAH, Ft. Howard, Md. Date signed 9-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09158

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County..... Baltimore

City or town..... Whitemarsh, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, Institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME
AMANDA HOLTZNER.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife..... William Holtzner

7. Birth date of deceased (mo. day, yr.) Oct. 18th, 1885

8. AGE:	Years	Months	Days	If less than one day
	62	10	20	hrs. min.

9. Birthplace..... Baltimore County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business Wight Distillery

MOTHER / FATHER	12. Name
	Edward Beares

	13. Birthplace
	Baltimore County, Md.

	14. Maiden name
	Lizza J. Blakeley

	15. Birthplace
	Baltimore County, Md.

16. Informant..... Mrs. Hazel Collins

Address 5003 Crosswood Ave.

17. burial
(Burial, cremation, or removal. Which?) Cemetery or crematory.....

Date thereof..... 9/11/48
(month) (day) (year)

Cemetery or crematory..... Fork Methodist

Location..... Fork, Md.

18. Funeral director..... Lazarahn Funeral Home

Address 7401 Belair Rd.

19. (Date rec'd by registrar) 9/10/48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Whitemarsh, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Ebenezer Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
215-03-1621

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 8 1948 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 26 1943 to June 29 1948

and that I last saw her alive on June 29 1948

Immediate cause of death.....

Cerebral Haemorrhage

Due to.....

Hypertensive Cardiovascular disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... **W.H. Miller** M. D. or other

Address..... Ridge Rd., Belair, Md. Date signed..... Sept 8/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, clearly and legibly, write the causes of death.

(I) is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09159

38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County

Baltimore
Lutherville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

Broadway Road

How long in hospital or institution?

3. (a) FULL NAME

Florence E Hood

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Atis Hood -

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

years

1861

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

12. Name

= (?)

13. Birthplace

= (?)

14. Maiden name

Whiting

15. Birthplace

(?)

16. Informant

Mrs. Hood

Address

Broadway Rd. Lutherville

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9-23-48
(month) (day) (year)

Cemetery or crematory

Greenmount Cemetery

Location

Wadsworth & Son

18. Funeral director

Address

Greenmount Ave & 32nd St

9/22/48

19. (Date rec'd by registrar)

Sw. Hedditch

Dm Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Lutherville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Broadway Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

-

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept. 20 1948 at 945 A.M.

21. I CERTIFY the death occurred on the date above stated; that I attended deceased from

Sept. 5 1948 to Sept. 20 1948.

and that I last saw her alive on Sept. 19 1948.

Immediate cause of death Heart disease, chronic

myocarditis

DURATION

2 yrs.

Due to Severe changes with arteriosclerosis 10 yrs +

Due to

Cellulitis left neck

6 days.

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Rollin Hudson M.D.

M. D. or other

Address

Towson Md.

Date signed

9/20/48.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No.

09160

33

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Preston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ht. Pleasant Sanatorium

How long in hospital or institution? 7 years & 4 months

3. (a) FULL NAME

Beatrice Horner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Thomas Horner

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

December 27, 1899

8. AGE:

Years
48Months
8Days
26If less than one day
hrs. min.

9. Birthplace

Russia
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Hymen Denneburg

MOTHER FATHER

12. Name

Russia

13. Birthplace

Rose Silverman

14. Maiden name

Russia

15. Birthplace

Mrs. Marie Horner

16. Informant

Address 2028 Eastern Ave., Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 24, 1948
(month) (day) (year)

Cemetery or crematory Oheb Shalom Cem.

Location Odonnell St.

18. Funeral director Sol Levinson & Bros.

Address 1124-1126 W North Ave.

19. (Date rec'd by registrar)

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09161
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
 County..... Baltimore
 City or town..... Catonsville.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 120 Maiden Choice Lane
 How long in hospital or institution? none

3. (a) FULL NAME
 Annie Hoffman Houghton

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
female	white	widowed		
8.(b) Name of husband or wife Louis S. Houghton				
6.(c) If alive, give age..... years				
7. Birth date of deceased (mo.. day.. yr.) January 31, 1869				
8. AGE:	Years 79	Months 2	Days 23	If less than one day hrs. min.

9. Birthplace..... Brownsville, Washington Co., Md.
 (Town, county, and state)

10. Usual occupation..... none

11. Industry or business

MOTHER FATHER	12. Name..... Ephriam Nice Warner
	13. Birthplace Loudon County, Va.
MOTHER	14. Maiden name..... Margaret Ann Newcomer
	15. Birthplace Hagerstown, Md.

16. Informant..... Mr. Reuben H. Houghton
 Address 127 Spa View Ave., Annapolis, Md.

17. Burial..... Date thereof..... Sept. 25, 1948
 (Burial, cremation, or removal, Which?) Cemetery or cemetery..... Loudon Park

Location..... 3801 Frederick Ave.

18. Funeral director..... John O. Mitchell & Sons Inc.
 Address 1900 Eutaw Place, Baltimore 17, Md.

F-24 1988 D3H
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 120 Maiden Choice Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1948, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1947, to 23 Sept. 1948, and that I last saw her alive on 22 Sept. 1948.

Immediate cause of death.....

Coronary occlusion

Due to..... arteriosclerotic hypertension
 Cardiovascular disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Hesbit, Jr. M. D. or other
 Address 20 E. Preston St., Balt. Date signed 24 Sept 1948

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09162

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution?

3. (a) FULL NAME

MELVIN R. HOUSE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	NEGro	Married - separated

6. (b) Name of husband or wife Eva House

7. Birth date of deceased (mo., day, yr.) February 22, 1910

8. (c) If alive, give age 35 years

8. AGE: Years Months Days If less than one day
38 6 17 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

12. Name Robert House
13. Birthplace Baltimore, Md.14. Maiden name Wilhemina Henry
15. Birthplace Baltimore, Md.16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland17. Burial Baltimore National Cemetery
(Burial, cremation, or removal. Which?)Date thereof Sept. 13 1948
(month) (day) (year)

Cemetery or crematory Location 5501 Frederick Ave. Balto. Md.

18. Funeral director Isaiah Brown

Address 108 Montgomery St. Balto. Md.

19. (Date rec'd by registrar) 9/11 1948

R.W. Hedrick
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 438 W. Conway St.

(If rural, give LOCATION)

2.(a) If veteran, name war WW-2

3. (b) Social Security Number

212-01-4938

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1948 at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1948 to Sept. 9 1948

and that I last saw him alive on September 9 1948

Immediate cause of death

PULMONARY TUBERCULOSIS, BILATERAL

DURATION

3 yrs.

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE Paul O. Anderson, M.D.

M. D. or other

VAH FT. Howard, Md.

Date signed 9-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09163

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

8 yrs.

Hospital, institution, or street address where death occurred.....

606 Brook Road

How long in hospital or institution?.....

3. (a) FULL NAME

Harry M. Huether

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Emma A. Berndt

Huether

6. (c) If alive, give age

59 years

7. Birth date of deceased (mo., day, yr.)

June 11, 1889

8. AGE:

59

Years

3

Months

16

Days

If less than one day

hrs.

min.

Baltimore, Maryland

(Town, county, and state)

9. Birthplace.....

Baltimore

Maryland

(Town, county, and state)

Reciter, Financial

Md Calig. Printing Co

Unknown

10. Usual occupation.....

Unknown

Unknown

(Town, county, and state)

Unknown

Unknown

(Town, county, and state)

11. Industry or business.....

Unknown

Unknown

(Town, county, and state)

12. Name.....

Harry M. Huether

Unknown

(Town, county, and state)

13. Birthplace.....

Unknown

Unknown

(Town, county, and state)

14. Maiden name.....

Unknown

Unknown

(Town, county, and state)

15. Birthplace.....

Unknown

Unknown

(Town, county, and state)

16. Informant.....

Mrs Emma A. Huether

Unknown

(Town, county, and state)

17. Address.....

606 Brook Rd

Towson

(Town, county, and state)

18. Funeral director.....

Lorrie Byers

Unknown

(Town, county, and state)

19. Address.....

5005 Park Height Ave

Baltimore

(Town, county, and state)

Date death by registrar.....

9/29/48

19

Date signed.....

9-28-48

Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09164

CERTIFICATE OF DEATH

138 Reg. Dijat. No. 358

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson I., Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos. 14 days

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson I., Md.

How long in hospital or institution? 7 mos. 14 days

3. (a) FULL NAME

William O. Hunt

4. Sex

M

W

5. Color or race

Single

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Belts

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Waterfront Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

243-26-5687

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 23 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Sept 23 1948

and that I last saw him alive on Sept 22 1948

Immediate cause of death Pulmonary Tbc

DURATION

1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.G. Bridges

M. D. Doctor

Address..... Towson I., Md.

Date signed.....

16. Informant Personal history-Hospital records

Address Eudowood Sanatorium, Towson I., Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof Sept 24, 1948
(month) (day) (year)

Cemetery or crematory

Biggs Funeral Home

Location

Lumberton, N.C.

18. Funeral director

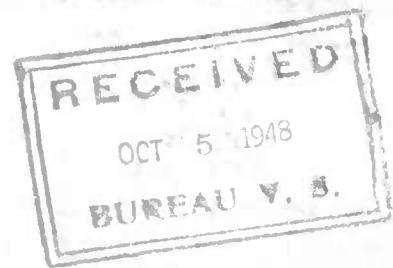
John Burns Sons

Address

Towson, Md.

19. Sept 23 1948 W. Carroll New Horn
(Date rec'd by registrar) Deputy Coroner

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09165

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills, Md (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs 10 mos 28 days

Hospital, institution, or street address where death occurred: Rosewood

How long in hospital or institution? 26 yrs 10 mos 28 days

3. (a) FULL NAME

Grace Virginia Shumon

4. Sex:

5. Color or race:

6.(a) Single, married, widowed, or divorced

f. w. s.

6.(b) Name of husband or wife:

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age years

August 25, 1881

8. AGE:

Years

Months

Days

If less than one day

67

11

0

7 hrs.

0 min.

9. Birthplace:

Tidewater Va

(Town, county, and state)

10. Usual occupation:

Inmate Rosewood

11. Industry or business:

Jas. Warner Shumon

12. Name:

Va

MOTHER FATHER

13. Birthplace:

Rachael Price

14. Maiden name:

Md.

15. Birthplace:

Institutional Record

16. Informant:

Burial

Address:

Owings Mills, Md

17. (Burial, cremation, or removal. Which?)

Cremation

Date thereof:

Sept. 11-48

(month) (day) (year)

Cemetery or crematory:

Friends Burial Ground

Location:

Baltimore City

18. Funeral director:

J. F. Elmer Sons

Address:

Baltimore Md

19. (Date rec'd by registrar)

9 - 8 - 1948

(Date rec'd by registrar)

Mary B. Eline.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va

County:

City or town: Tidewater Va (Rural)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH:

6 Sept

19 48

af 7t

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 1948 to 6 Sept 1948

and that I last saw her alive on 6 Sept

19 48

Immediate cause of death:

Aden-papillary carcinoma
of ovary with metastasis
to liver

DURATION

5 mos

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: See above

Date of op. 8/2/48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

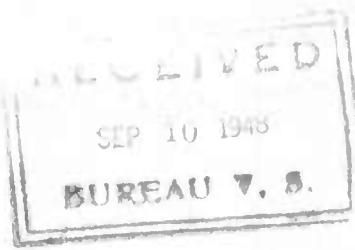
23. SIGNATURE:

J. S. Butler

M. D. or other

Address: Owings Mills, Md Date signed: 6 Sept 48

M
✓
correct age



(1949 Revision of Standard Certificate)
CERTIFICATE OF DEATH

Form approved.
Budget Bureau No. 68-R375.

BIRTH NO.		STATE OF		STATE FILE NO.	
I. PLACE OF DEATH				303	
a. COUNTY		Baltimore		30	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		Catonsville	c. LENGTH OF STAY (In this place)	since 6/10 1948	
d. FULL NAME OF HOSPITAL OR INSTITUTION		Spring Grove State Hospital			
3. NAME OF DECEASED (Type or Print)		a. (First) Anna	b. (Middle) Virginia	c. (Last) JACKSON	
5. SEX		6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	4. DATE OF DEATH	
F		W	Widowed	September 26, 1948	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Rooming house manager				IF UNDER 1 YEAR	IF UNDER 14 HRS.
(Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Months	Days
No		none		Hours	Min.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Terminal pneumonia			
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (o) stating the underlying cause last.</i>		DUE TO (b) C. N. S. lues			
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		DUE TO (c)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g. In or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6/10/1948 , 19_____, to 9/26/1948 , 19_____, that I last saw the deceased alive on 9/25/1948 , 19_____, and that death occurred at 5:40 A.m. , from the causes and on the date stated above.					
23a. SIGNATURE <i>Abraham M. Schneidmuhl, M.D.</i>		(Degree or title) <i>Surgeon</i>		23b. ADDRESS Spring Grove Hospital	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/29/48		24c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	
DATE REC'D BY LOCAL REG. 9/28/48		REGISTRAR'S SIGNATURE <i>Dr. Heinrich</i>		25. FUNERAL DIRECTOR WM. J. TICKNER & SONS	
				ADDRESS Balto., Md.	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167 Registered No. XX

1. PLACE OF DEATH
 (a) Baltimore City, Maryland
 (b) Street address.....
 (c) Hospital or institution:
Ft. Howard Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) **10 hrs.**
 (e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Md.** (b) County.....
 (c) City or town **Balto.,**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.
 (If rural give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3 (a) FULL NAME **LEDUS JENKINS**

3 (b) If veteran, name war	3 (c) Social Security Account No.
----------------------------	-----------------------------------

4. Sex M	5. Color or race C	6 (a) Single, married, widowed, or divorced. Single
-----------------	---------------------------	--

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1920**

8. AGE: Years 28	Months	Days	If less than one day hr. min.
-------------------------	--------	------	---------------------------------------

9. Birthplace **Washington, N.C.**
 (Town, county, and state)

10. Usual Occupation **Laborer**

11. Industry or business

12. Name **Solomon Jenkins**

13. Birthplace **N. C.**

14. Maiden Name **Emily ?**

15. Birthplace **N. C.**

16 (a) Informant **Wm. McCabe**

(b) Address **215 Sharp Street**

17 (a) **Shipped** (b) Date thereof **9-22-48**
 (Visit, examination, or removal) (month) (day) (year)

(c) Cemetery or crematory **Washington, N.C.**
 Location **A. Halstead**

18 (a) Funeral director.....

(b) Address.....

19 (a) **9/22/48** (b) **Levi Jenkins**
 (Date rec'd by registrar) **J.W. Registrar**

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 19, 1948, at 2:02 P.M.**

21. I certify that I took charge of the remains described above, held an Autopsy..... thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to..... death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Henningsen due to stab wound of back

Due to.....

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury.....

23. Signature *Ed. R. Jr.* M.D.

Date signed *7-18-48* Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *pre*

2411 N. Charles St., Baltimore

09168

Reg. Dist. No. *44*

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County *Baltimore*City or town *Fort Howard*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *16 days*

Hospital, institution, or street address where death occurred:

*Veterans Administration Hospital*How long in hospital or institution? *16 days*

3. (a) FULL NAME

RUFUS JOHNSON4. Sex *Male* 5. Color or race *Colored* 6.(a) Single, married, widowed, or divorced *Married (Sep.)*8.(b) Name of husband or wife *Sarah Johnson*7. Birth date of deceased (mo., day, yr.) *January 25, 1890*8. AGE: Years *58* Months *7* Days *22* If less than one day hrs. min.9. Birthplace *Jordan, South Carolina*
(Town, county, and state)10. Usual occupation *Unemployed*

11. Industry or business

12. Name *Jim Johnson*13. Birthplace *South Carolina*14. Maiden name *Martha Helden*15. Birthplace *South Carolina*16. Informant *Clinical Records, VET. Adm. Hosp.*Address *Fort Howard, Maryland*17. Burial Date thereof *9/20/48*
(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Baltimore National Ct.*Location *Baltimore City*18. Funeral director *Isaac L. Brown, Jr.*Address *108 W. Montgomery St., Baltimore, Md.*19. *Sept. 17 48 a. w. pedrick*
(Date rec'd by registrar) *98* Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Baltimore* (If outside city or town limits, write RURAL and give nearest town)Street No. *1101 Russell St.* (If rural, give LOCATION)2.(a) If refers, name was *W.W.I.*

3. (b) Social Security Number

218-10-4601

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 16* *1948* at *3:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 31 *1948* to *September 16* *1948*and that I last saw him *alive* on *September 16* *1948*

Immediate cause of death

PULMONARY HEMORRHAGEDue to **PULMONARY TUBERCULOSIS,
BILATERAL, FAR ADVANCED.**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **Substantiated above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

PAUL PADGET, M.D., ACTING CHIEF, MEDICAL STAFFAddress *VAH, Fort Howard, Md.* Date signed *9/16/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09169

CERTIFICATE OF DEATH

Reg. Dist. No. EX-1

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

309 Avondale RdHow long in hospital or institution? —

3. (a) FULL NAME

Theodore Roosevelt Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MColoredDivorced

6. (b) Name of husband or wife

Betty Green Johnson

7. Birth date of deceased (mo., day, yr.)

June 12, 1904

8. AGE:

Years

44

Months 3 Days 13 If less than one day

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Plummer Helper

11. Industry or business

Construction Co.

12. Name

Stalter P. Johnson

13. Birthplace

Baltimore, Md.

14. Maiden name

Maryj. Morton

15. Birthplace

Baltimore, Md.

16. Informant

Albert Johnson

Address

515 New Pittsburgh Ave

17. Burial

Date thereof

Sept. 26, 1948

(Burial, cremation, or removal which)

(month, day)

Cemetery or crematory

Shilo Baptist Church

Location

Oxford n.e.

18. Funeral director

Elyoy O'Wilson

Address

1000 Franklin St.

(List rec'd by registrar)

19. Date signed

1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

309 Avondale Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 23, 1948, at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1948 to September 23, 1948and that I last saw him alive on September 23, 1948.

Immediate cause of death

Bronchial Pneumonia

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William J. Dako, M.D.

M. D. or other

Address

140 Oak Ave

Date signed

9-2-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09170

CERTIFICATE OF DEATH

44

Reg. Dist. No. 44

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 12 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution?..... 12 days

3. (a) FULL NAME

WILLIAM H. JOHNSON

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Widowed

6. (b) Name of husband or wife..... Widowed

7. Birth date of deceased (mo., day, yr.)

June 17, 1888

6. (c) If alive, give age..... years

8. AGE:

Year	Months	Date	If less than one day
60	2	22	hrs. min.

9. Birthplace..... Richmond, Virginia
(Town, county, and state)

10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Aaron Johnson

13. Birthplace..... Virginia

14. Maiden name..... Mary Williams

15. Birthplace..... Virginia

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

17. Burial.....

(Burial, cremation, or removal. Which?) Date thereof..... 9/14/48

Cemetery or crematory..... Baltimore National Cemetery

Location..... Baltimore, Md.

18. Funeral director..... Charles R. Law

Address..... 802 Madison Ave., Balto., Md.

19. Supt. 11 1948 William M. Kelly Jr.
(Date rec'd by registrar) Dauver J. Larken Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 1609 W. Lanvale St.

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW I

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 9 1948 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 28 1948, September 9 1948

and that I last saw him alive on September 9 1948

Immediate cause of death.....

CARDIAC DILATATION AND HYPERSTROPHY

DURATION

Unknown

Due to.....

Due to.....

Other condition..... Pulmonary Tuberculosis

Unknown

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... VAH Fort Howard, Md. Date signed 9-10-48



PLEASE WRITE PLAINLY WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09171

93d

30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County **Baltimore**City or town **Catonsville**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **2 months, 22 days**

Hospital, Institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? **2 months, 22 days**

3. (a) FULL NAME

Mary B. Kelly

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

May 10, 1866

8. AGE:

Years
82Months
3Days
27

If less than one day

hrs.
.....min.
.....

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

MOTHER FATHER

12. Name **Hugh Kelly**13. Birthplace **Ireland**14. Maiden name **Mary Moshall** Mary E. Hoshall15. Birthplace **Maryland**

16. Informant

Hospital records

Address

Catonsville-28, Maryland

17. Burial

(Burial, cremation, or removal, which)

Date thereof Sept. **7/48**
(month) (day) (year)

Cemetery or crematory

Baltimore, Md.

Location

Elmwood Cemetery

Name

of

deceased

Isadore Tuerk, M.D.

Signature

of

Isadore Tuerk, M.D.

805 North Calvert St. Balto.

Address

9/7 1948

(Date rec'd by registrar)

R.W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**

County

City or town **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **Seton Institute**

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 6

1948

at 12:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15

1948

to **September 6** 1948and that I last saw her ~~alive~~ alive on **September 6** 1948

Immediate cause of death

Terminal pneumonia, both basesDue to **Hypertensive cardiovascular-renal disease**Due to **Arteriosclerosis, generalized**Other conditions **Arthritis deformans**

DURATION

5 days

indefinite

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results **none**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Isadore Tuerk, M.D.

M. D. or other

Catonsville-28, Maryland

Date signed **9-6-48**

Address

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09172

CERTIFICATE OF DEATH

94a
38
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Baltimore
Rogers' Forge (Towson 4)City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 years

Hospital, institution, or street address where death occurred:

85 Murdock Road

How long in hospital or institution?.....

3. (a) FULL NAME

Dorothy Cheshire Kenty

4. Sex

Female White Married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband

wife Williams Y. Kenty

7. Birth date of deceased (mo., day, yr.)

Jan. 21, 1904

6.(c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day
44 8 9 hrs. min.

9. Birthplace

Bloomington, Ill.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

MOTHER FATHER

Name..... Pearl Cheshire

13. Birthplace

Ill.

14. Maiden name

Jessie McIntire

15. Birthplace

Ill.

16. Informant

Williams Y. Kenty

Address

85 Murdock Rd, Towson 4 Md.

17. Burial

Date thereof Oct 2, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Prospect Hill Cemetery

Location

Towson, Maryland

18. Funeral director

John Burns Sons

Address

Towson, Maryland

19.

(Date rec'd by registrar) 19.....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town..... Rogers' Forge (Towson 4)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 85 Murdock Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 30 1948 at 11A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death Heart disease, cerebral
with coronary occlusion, sudden

Duration sudden

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bolling C. Hudson M.D. P.M.E.

M. D. or other

Address Towson Md. Date signed 9/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09173

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County.....

Baltimore
Catonsville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

George Money Kimberly

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife.....

Alice Roberts

B. (c) If alive, give age..... years

Aug. 1, 1870

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

North Carolina

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

FATHER

12. Name.....

John Kimberly

New York

13. Birthplace.....

MOTHER

14. Maiden name.....

Eliz. Money

15. Birthplace.....

North Carolina

16. Informant.....

John Ralph Kimberly

Address

Belle Grove Rd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 9-13-48

(month) (day) (year)

Cemetery or crematory.....

Greenwood Park Cem.

Location.....

Baltimore

18. Funeral director.....

George A. Farley

Address

Fuller & Fayette St.

19. 9-13-48
(Date rec'd by registrar)J. E. Harry
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Baltimore

City or town.....

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Belle Grove Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept. 11-1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1940 to September 11, 1948

end that I last saw him alive on September 10, 1948

Immediate cause of death.....

Coronary Occlusion

Due to.....

Arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

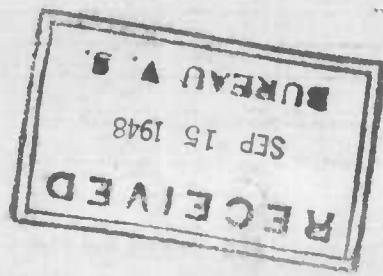
Injured at work?

23. SIGNATURE.....

Welchke Farley

M. D. or other _____ Date signed 8/11/48

Address 20 S. Boston St -



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09174

164a

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Balto
arbutus

How long in above place of death?

Hospital, institution, or street address where death occurred:

936 Elm Ridge ave

How long in hospital or institution?

3. (a) FULL NAME

Ruth R Koehler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

7 w married

6. (b) Name of husband or wife

George M

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.)

Sept 4 1905

8. AGE:

Years

Months

Days

If less than one day

43 6 28

hrs. min.

9. Birthplace

(Town, county, and state)

Balto
arbutus

10. Usual occupation

Housewife

11. Industry or business

Harry Steele

MOTHER FATHER

12. Name

Birthplace

Balto

Maiden name

Oklahoma Koehler

15. Birthplace

Balto Md

16. Informant

Geo. R. Koehler

Address

936 Elm Ridge ave

17. Burial, cremation, or removal (What?)

Burial Date thereof 9-6-48

(month)

(day)

(year)

Cemetery or crematory

London Park

Location

Balto

18. Funeral director

Frederick a Cole

Address

1200 W Lombard St

Sept 5 1948

(Date rec'd by registrar)

Ge Koffler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Balto

City or town

arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No.

936 Elm Ridge ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 2 1948 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

18...

and that I last saw h... alive on

19...

Immediate cause of death

Strangulation
hanging

Due to

Due to

Other conditions

Suicid

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Suicide

Date of

9-2-48

Where did injury occur?

arbutus

(City or town)

Balto Md

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

home in
from water pipe to roof in

Injury at work?

23. SIGNATURE

Geo. McKinney Koehler
M. D. or other

Address

1010 Dundon Ave

Date signed

9-2-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible answers will not be accepted. Physicians: please write the causes of death clearly and legibly.

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09175

46d

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

VETS. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 17 days

3. (a) FULL NAME

GEORGE R. KREPS

George R.

4. Sex

5. Color or race

8. (a) Single, married, widowed, or divorced

Male M

white

married

8. (b) Name of husband or wife

Edith B. Kreps

8. (c) If alive, give age 56 years

7. Birth date of deceased (mo. day, yr.)

March 2, 1879

8. AGE:

Years
69Months
6Days
23

If less than one day

hrs.

min.

9. Birthplace

Greenville, Pa.

(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

12. Name William Kreps

13. Birthplace Greenville, Pa.

14. Maiden name Lucetta Taylor

15. Birthplace Penna.

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Removal Date thereof 9/27/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Castle, Pa. (Oak Park Cem.)

Location

18. Funeral director William J. Tickner

Address North & Penna. Aves. Balto. Md.

19. Sept 27 1948

(Date rec'd by registrar)

A.W. Hefrich

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1548 North Gate Rd. Balto. Md.

(In rural, give LOCATION)

2.(a) If veteran, name war SAW ✓

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25

19. 48, 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 8

19. 48, to Sept. 25 19. 48

and that I last saw him alive on Sept. 25 19. 48

Immediate cause of death

CARDIORESPIRATORY FAILURE

Due to Probable Coronary Thrombosis

unknown

Due to

Other conditions Carcinoma of Rectum

4 mos.

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work? A.E. Pugh, M.D.

23. SIGNATURE A.E. Pugh, M.D.

M. D. or other

Address VAH FT. Howard, Md. Date signed 9-25-48

09176

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 45

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, write the cause of death clearly and legibly. This is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Baltimore
Rosedale

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John L Langerfelder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Elizabeth Langerfelder

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Sept 8 1879

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Baltimore Co

10. Usual occupation

farmer (retired)

11. Industry or business

MOTHER FATHER

12. Name George Langerfelder

13. Birthplace Md

14. Maiden name Lena Lang

15. Birthplace Md

16. Informant Geo H Langerfelder

Address 7623 Phila Road

17. Burial, cremation, or removal. Which? Burial

Date thereof Sept 8 1948

(month) (day) (year)

Cemetery or crematory Jason Cem

Location Glenarm Run Md

18. Funeral director. Wm. Funeral Home

Address 2008 Orleans St.

19. Sept 6 1948

Baltimore 4 D

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

Rosedale

Street No.

7623 Phila Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 2 1948 at 11¹⁰ M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 1 1948 to Sept 2 1948 and that I last saw him alive on Sept 2 1948

Immediate cause of death

Cerebral apoplexy

DURATION

3 days

Due to

Atherosclerosis

Cardio-vascular disease 2 yrs

Due to

Diabetes mellitus 3 yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Baltimore 6 Date signed 9-3-58

SEP 7 - 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09177
131a

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
Maude O'Dell Larmore

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Marion A. Larmore

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1908 8. (c) If alive, give age 45 years

8. AGE: Years 39 Months 9 Days 13 It less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name George Edward Jones

13. Birthplace Maryland

14. Maiden name Mary Alice Crue

15. Birthplace Maryland

16. Informant Marion A. Larmore
Address Cockeysville, Md.

17. Burial Burial Date thereof Sept. 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Piney Woods Cemetery

Location Tallie Road, Cockeysville, Md.

18. Funeral director John Burns, Sons

Address Towson, Md.

19. 9 - 11 - 48 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1948 at 5 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 to Sept. 10, 1948, and that last saw her alive on Sept. 3, 1948.

Immediate cause of death Coronary Thrombosis

Due to Chronic Myocarditis

Due to Arterial Hypertension

Other conditions Chronic Nephritis

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work _____

23. SIGNATURE E. E. Nichols, M.D.

M. D. or other _____

Date signed 9/11/48

Address _____



I

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0917843
Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

Baltimore

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7410 Kenleigh Ave

How long in hospital or institution?

22 yrs

3. (a) FULL NAME

Dorothy Marguerite Lewis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fem. White Widow -
Audrey Dennis -

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

Feb 27 1864

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

8. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 6/48

(month) (day) (year)

Cemetery or crematory

Oak Lawn Cem.

Location

Baltimore

reg.

18. Funeral director

Address

Lassahn Funeral Home

740, Belair Rd.

Address

Sept. 4

1948

Mrs. A. L. Reynolds

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 3 1948 at 6:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10...

to

and that I last saw h. alive on

10.

Immediate cause of death

Hepatitis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Address

9/3/48

M. D. or other

Dr. [Signature]

Baltimore City Hospital



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09179

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County.....

Balto

City or town.....

Granite

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

offutt road

How long in hospital or institution?

3. (a) FULL NAME

Mary V. Lindemann

4. Sex

W

5. Color or race

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

James J

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

May 15 1857

8. AGE:

Years
91Months
3Days
7

II less than one day

hrs. min.

9. Birthplace.....

Hagerstown Md

(Town, county, and state)

10. Usual occupation.

11. Industry or business

House wife

MOTHER FATHER

12. Name.....

Mrs. Mary Ann

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Arthur Lindemann

Address

Granite and

17. Burial, cremation, or removal. Which?

Date thereof 9-3-48

Cemetery or crematory

Jefferson Methodist

Location

Hagerst Md.

18. Funeral director.....

I. Scott Brooks

Address

Spurred, Md.

19. (Date rec'd by registrar)

9/6/

19

Mrs. E. Martin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Balto

City or town.....

Granite

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Offutt Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1

19

19

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h..... alive on

19...

Immediate cause of death.....

Acute cardiac failure

Due to.....

Cardiovascular disease

Other conditions.....

Senility

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Dr. M. Kieffer Esq. M.D. or other

Address 1010 Leader St Date signed 9-1-48

Dist. #2



Young & Co

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09180

44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 68 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.

How long in hospital or institution?..... 68 Days

3. (a) FULL NAME

RAYMOND P. LITTLE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

8. (b) Name of deceased wife

Catherine Little

7. Birth date of deceased (mo., day, yr.)

4-18-20

8. (c) If alive, give age..... 25 years

8. AGE:

Year

Month

Days

If less than one day

28

5

10

hrs.

min.

9. Birthplace..... McSherrytown, Pa.

(Town, County, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... John J. Little

13. Birthplace..... Pennsylvania

14. Maiden name..... Mary Smith

15. Birthplace..... Pennsylvania

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

17. Removal.....

Date thereof..... September 29, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... St. Mary's Cemetery

Location..... McSherrytown, Pennsylvania

18. Funeral director..... Joseph T. Kieran

Addressee..... McSherrytown, Pennsylvania

19. Date rec'd by registrar..... Sept 29, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pennsylvania County.....

City or town..... McSherrytown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... none

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-2

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 28, 1948, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 1948, 19..... to Sept. 28, 1948, and that I last saw him alive on September 28, 1948.

Immediate cause of death..... Chronic Nephritis

DURATION Unknown

Due to.....

Due to.....

Other conditions of the brain..... Infarct rt. Temporal Lobe

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

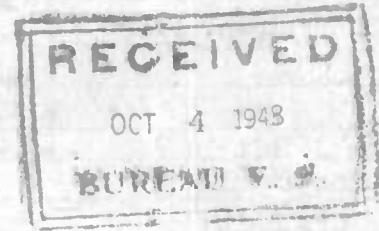
23. SIGNATURE.....

P.W. ROMAN, M.D.

M. D. or other

Address.....

Date signed.....



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09181

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County.....

Baltimore
Catonsville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

7 Weeks

3. (a) FULL NAME

William J. Llewellyn

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Grace Agnes Llewellyn

7. Birth date of deceased (mo., day, yr.)

June 18 1869

8. (c) If alive, give age years

8. AGE:

Years 79 Months 2 Days 3 If less than one day 0 hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

William R. Llewellyn

12. Name

Va

13. Birthplace

Aurora Brown

14. Maiden name

Aurora Brown

15. Birthplace

Yes

16. Informant

Mr. Robert Llewellyn

Address

3717 Harmon Ave

17. Burial

Date thereof Sept 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

London Park Cem

Location

Baltimore, Md.

18. Funeral director

Ellis Funeral

Address

4510 Liberty Heights Ave

19. (Date read by registrar)

9/20 1948

A.W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland Co. Baltimore

City or town.....

Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3717 Harmon Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1948 st 4 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 d. 1946 to Sept 18 1948

and that I last saw him alive on Sept 18 1948

Immediate cause of death

11 - Asthma - Aclerotic
cardio - vascular disease

DURATION

5 yrs?

Due to

Due to

Other conditions

Broncho - pneumonia

1 day

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other

Address 4108 Liberty Hts. Ave Date signed Sept 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09182

CERTIFICATE OF DEATH

Reg. Dist. No. 44

95c

1. PLACE OF DEATH:
County Baltimore
City or town Gray Manor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Gray Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2801 McComas
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Fannie Carter Lockamy

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John S. Lockamy

7. Birth date of deceased (mo., day, yr.) Jan. 12 - 1876 years

6.(c) If alive, give age..... years

8. AGE: Years 72 Months 9 Days 18 If less than one day
..... hrs. min.

9. Birthplace Parkersburg, W. Va.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER 12. Name Louis Carter
13. Birthplace N. Carolina
14. Maiden name Fannie McDaniels
15. Birthplace N. Carolina

16. Informant J. N. Lockamy
Address 2801 McComas, Gray Manor

17. Burial, cremation, or removal? Entombment Date thereof Sept. 30 - 1948
(month) (day) (year)

Cemetery or crematory Tamptation Cemetery
Location Roseboro, N. Carolina

18. Funeral director John S. Connally
Address 408 Eastern Ave. Essex

19. (Date rec'd by registrar) Sept. 30 - 1948 John S. Connally
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 September 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 1948 to 30 Sept. 1948 and that I last saw her alive on 30 Sept. 1948. Immediate cause of death Heart Failure

DURATION
Due to	<u>Chronic Heart Disease 10 yrs.</u>
Due to
Other conditions
(Include pregnancy within 8 months of death)	
Major findings or operations	
..... Date of op.	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of.....	
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of injury	
Injured at work?	
23. SIGNATURE <u>W. Herbert Morrison</u>	
M. D. or other	
Address <u>2534 Parkway</u> Date signed <u>2 Oct. 48</u>	



PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09183

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: BaltimoreCity or town: Cockeysville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 yrsHospital, institution, or street address where death occurred: Masonic Home, Cockeysville Md.How long in hospital or institution? 1 1/2 yrs

3. (a) FULL NAME

Gertrude Lorchess

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife: Nathan C. Lorchess

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 18728. AGE: Years 76 Months 6 Days 15 If less than one day hrs. min.9. Birthplace: Town Point Md.
(Town, county, and state)10. Usual occupation: Nursing

11. Industry or business

12. Name: John T. Purser13. Birthplace: Md.14. Maiden name: Mary Jane Canaan15. Birthplace: Md.16. Informant: Laura M. SchroederAddress: Masonic Home, Cockeysville Md.17. Burial: Bethel Cemetery, Chesapeake City

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Bethel Cemetery, Chesapeake CityLocation: Chesapeake City Md.18. Funeral director: Wm. CookAddress: St. Paul & Preston St19. Sept. 7th 1948 Z. M. Schroeder

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Jersey County:City or town: Maywood N.J.
(If outside city or town limits, write RURAL and give nearest town)Street No. 125 Park Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6 1948 at 5:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4 to Sept. 6 1948, and that I last saw her alive on Sept. 6 1948.

Immediate cause of death

Coronary ThrombosisDue to: Arterio-sclerosis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

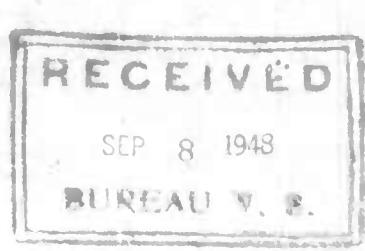
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Walter T. Kees M.D. M. D. or otherAddress: Cockeysville Md. Date signed: 9/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 09184
44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution?..... 11 days

3. (a) FULL NAME

JEREMIAH FLETCHER LUTZ

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife..... Lottie E. Lutz

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo. day, yr.) November 25, 1872

8. AGE: Years Months Days If less than one day
75 9 16 hrs. min.9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... physician

11. Industry or business

12. Name..... unknown

13. Birthplace..... Baltimore, Md.

14. Maiden name..... Mary Richmond

Baltimore, Md.

15. Birthplace.....

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

17. Burial Date thereof..... Sept. 14, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Union

Location..... Glen Rock Pa.

18. Funeral director..... H. C. Gable

Address..... Maryland

19. Date rec'd by registrar..... 9-11-48

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pennsylvania County.....

City or town..... Glenrock

(If outside city or town limits, write RURAL and give nearest town)

Street No..... none

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-1

3. (b) Social Security Number

UNKNOWN

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 11 1948 at 6:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31 1948 to Sept. 11 1948

and that I last saw him alive on September 11 1948

Immediate cause of death

Arteriosclerosis, generalized, sev.

Coronary Arteriosclerosis

xx Cerebral Arteriosclerosis

DURATION

2yrs plus

2 yrs plus

2yrs plus

Due to

Due to

Other conditions..... None

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

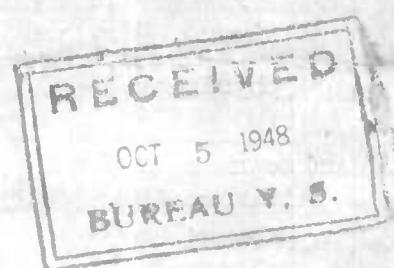
Means of injury

Injured at work?

23. SIGNATURE..... RUSSELL BRANDON, M.D.

M. D. or other

Address..... VAH Ft. Howard, Md. Date signed 9-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09191

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 15 minutes

3. (a) FULL NAME

MIKE MALCZEWSKI

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

B.(b) Name of husband or wife deceased

7. Birth date of deceased (mo., day, yr.)

May 19, 1892

B.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

56

4

5

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Factory worker

11. Industry or business

12. Name Jacob Malczewski13. Birthplace Poland14. Maiden name Josephine Kordenski15. Birthplace Poland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

9/28/48

Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Ave. Balt. Md.18. Funeral director William CookAddress St. Paul and Preston Sts. Balt. Md.19. Sept 21

(Date rec'd by registrar)

19. 4819. Army Hospital19. 4819. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1200 S. Ellwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war WW-1

3. (b) Social Security Number

218-01-8003

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 19. 48 st. 7:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 19. 48 to September 24 19. 48and that I last saw him alive on September 24 19. 48

Immediate cause of death

multiple Contusions
scaphoid Fracture (Rock Eye)Due to
Fracture of skull
with extensivesubarachnoid hemorrhage
about base of brain.

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results substantiated above - No lung definite
PHYSICIAN: Please underline the cause to which death should be attributed22. VIOLENCE: If death was due to external causes, list in the following: from
Accident, suicide, or homicideWhere deceased at home (City or town) (County) (State) Md.Injured at home, farm, industry, public place (where?) at home (City or town) (County) (State) Md.Means of injury fall Injured at work?23. SIGNATURE John Malczewski M.D.
M.D. or otherAddress 5501 Frederick Ave. Balt. Md. Date signed 9/21/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09185
48b

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH

County.....

Baltimore
Brecksville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Maggie D. Martin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

M

6. (b) Name of husband or wife

Charles A. Martin

6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.)

April 9-1872

8. AGE:

Years

Months

Days

Less than one day

hrs.

min.

9. Birthplace

Maryland

(town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Aaron Cleggson

13. Birthplace

Md

14. Maiden name

Angelina Kemp

15. Birthplace

Md

16. Informant

Charles A. Martin

Address

Stamfatead Md R.D.

17. Burial

Date thereof Sept 22-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt Zion

Location

Baltimore Md

18. Funeral director

Eddy & Gipton

Address

Stamfatead Md

19.

9-22-48

(Date rec'd by registrar)

19. 9-22-48

Mary Rd. Eliza

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 19 48 at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 48 to Sept 19 48

and that I last saw her alive on Sept 19 48

Immediate cause of death

Cerebrum

DURATION

3 mo.

Due to

Carcinoma of uterus

89 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. O'Farrell

M. D. or other

Address

Date signed



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 451

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

Raspeburg #6

(b) Street address 1206 N. 62nd. Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

3 (a) FULL NAME

William Pearl McCann

3 (b) If veteran, name war

Spanish

3 (c) Social Security Account

No. ---

4. Sex

5. Color or race

Male

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Marion V. McCann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1876

8. AGE: Years Months Days If less than one day
72 1 20 hr. min.

9. Birthplace Ohio

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Samuel McCann

13. Birthplace Ohio

14. Maiden Name Pearl---

15. Birthplace Unknown

16 (a) Informant Mrs. Marion V. McCann

(b) Address 1206 N. 62nd. Street

17 (a) Burial (b) Date thereof Sept. 23/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory U.S. National Cem

Location Balto. Md.

18 (a) Funeral director Philip Henry And

(b) Address 2024 Orleans St.

19 (a) SEP 20 1948 Huntington Library, Inc.
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore Raspeburg #6
(If outside city or town limits, write RURAL and give town)(d) Street No. 1206 N. 62nd. Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1948 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1948 to 9/20 1948, and that I last saw him alive on 9/20 1948. Immediate cause of death pronounced him dead

Carcinoma of Tongue Duration 18 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph Pakorny M.D.

Address 2200 E Madison St Date signed 9/20/48

Attended by J. Maldeis, M.D.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

SET 21/1948

I

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09190

83a

30

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Baltimore

County

Catonsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

5222 Edmondson Highway

How long in hospital or institution?

3. (a) FULL NAME

Rose F. McCormick

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas J. McCormick

7. Birth date of deceased (mo., day, yr.)

Aug. 7, 1876

6. (c) If alive, give age..... years

8. AGE:

72

Year

1

Months

17

Days

If less than one day

hrs.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual occupation

H. W.

11. Industry or business

John Cook

12. Name

John Cook

13. Birthplace

Germany

14. Maiden name

Elizabeth Pfeiffer

15. Birthplace

Md.

16. Informant

Thomas J. McCormick

5222 Edmondson Highway

Address

Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

New Cathedral

Location

4300 Old Frederick Rd.

Harry H. Kutzle

Addressee

4101 Edmondson Ave.

Date rec'd by registrar

19. Sept 25 1948

(Date rec'd by registrar)

10. Hospital

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5222 Edmondson Highway

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 24/48.

19.

at

7A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 6

1948

to Sept 24

1948

and that I last saw her alive on Sept 23

1948

Immediate cause of death

Cerebral Hemorrhage - 3 days

DURATION

Due to

Cerebral Arterio Sclerosis

Due to

Parkinsonian Syndrome

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Meane of injury

Injured at work?

23. SIGNATURES

Deceased or widow

M. D. or other

Name

Date signed

9-24

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

178a

09188

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X. PLACE OF DEATH:

County Baltimore Co.

City or town Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

1410 Ridge Rd

How long in hospital or institution?

3. (a) FULL NAME

Mary Ellen McLellan (McLellan)

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

March 13, 1937

8. AGE:

Years Months Days If less than one day

11 5 26 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

12. Name Philip McLellan

13. Birthplace W. Hartford, Conn.

14. Maiden name Mildred G. Walter

15. Birthplace Baltimore, Md.

16. Informant Philip McLellan

Address 15 Fieldbridge Rd., Hartford, Conn.

17. Cremation Date thereof Sept 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore, Md.

18. Funeral director Edward A. MacMabb, Jr.

Address Catonsville, Md.

19. 9-11 1948 V.E. Harry

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balt.

City or town Catonsville 2d

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1410 Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 9 48 av 1130a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18. to 19.

and that I last saw h. alive on

Immediate cause of death

Arphyseptic by
Electroshock Tym

Due to

Due to all turned person face down
in kitchenOther conditions gave person turned on to
mildred McLellan (Mother)
(Include pregnancy within 8 months of death)
Suicide

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Catonsville, Balt. (City or town)

(County) (State)

Injured at home, farm, industry, public place (where)?
Person in kitchen stone home
Means of injuryInjured at work Garage
Date of op. 9-11-48

23. SIGNATURE

M. D. or other

Address 1010 Reeds Ave. Date signed 9-10-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09187

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Baltimore, Md.

City or town Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

1410 Ridge Rd

How long in hospital or institution?

3. (a) FULL NAME

Mildred L. McLellan (McGilligan)

3. (b) Social Security Number

4. Sex

Female White divorced

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 9, 1906

6.(c) If alive, give age years

8. AGE:

Years 42 Months 6 Days 0 If less than one day hrs. 0 min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Housewife

12. Name

George Walter (WALTER)

13. Birthplace

Maryland

Hartings

14. Maiden name

Mildred

15. Birthplace

Germany

Philip McLellan

16. Informant

Philip McLellan

Address

15 Weldbridge Rd, Hartford, Conn

17. Cremation

Date thereof Sept 11, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Maryland

18. Funeral director

Edward J. MacNabb, Jr.

Address

Catonsville, Md.

Date rec'd by registrar

9-11-1948

V.E. Harry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Balt.

City or town Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1410 Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 9 1948 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....

19.....

and that I last saw h.....alive on

19.....

Immediate cause of death

asphyxiation by
Electrocution

Due to

Due to

suicide

Other conditions all burns found on
gas range in kitchen

(Include pregnancy within 8 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

suicide

Date of Sept 9 1948

Where did injury occur?

Catonsville

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

gas from kitchen stove

injured at work?

home

23. SIGNATURE

Leslie Kieffer, Esq., Baltimore

M. D. or other

1010 Linda Dr.

Date signed 9-10-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09189

178a

Reg. Dist. No. 30

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Baltimore Co.
City or town Catonsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

1410 Ridge Rd.

How long in hospital or institution?

3. (a) FULL NAME

Philip Mc cellar

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1938

8. (c) If alive, give age years

8. AGE: Years 10 Months 2 Days 1 It less than one day

hrs. min.

9. Birthplace West Hartford, Conn.

(Town, county, and state)

10. Usual occupation

student

11. Industry or business

12. Name Philip Mc cellar13. Birthplace W. Hartford, Conn.14. Maiden name Mildred L. Water15. Birthplace Baltimore, Md.16. Informant Philip Mc cellarAddress 15 Weldbridge Rd. Hartford Conn.17. Cremation Date thereof Sept. 11, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory London ParkLocation Baltimore Md.18. Funeral director Edward J. Mac Nabby Jr.Address Catonsville Md.19. 9-11-1948 (Date rec'd by registrar)J.E. Harry (Signature)
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville 25 (If outside city or town limits, write RURAL and give nearest town)Street No. 1410 Ridge Road (If rural, give LOCATION)

2. (a) If veteran, name war

(Mc cellar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 48 at 11-30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18. to. 19.

and that I last saw h. alive on

Immediate cause of death

asphyxiation by
electrocuting gas

Due to

Due to all burn turned on gas stoveOther conditions in kitchen

(Include pregnancy within 8 months of death)

Major findings or operations

gas burner turned on by
Mildred J. Mc cellar Date of op. suicide

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Sept 9, 48Where did injury occur? Catonsville (City or town) Baltimore (County) Md. (State)Injured at home, farm, industry, public place (where?) homeMeans of Injury gas from kitchen stove Injured at work? gas rangeof gas burned23. SIGNATURE John Keffler M. D. or other exam. dateAddress 1010 Leeds Dr. Date signed 9-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

09192

33

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.City or town Woodensburg

(If outside city or town limits, write RURAL and give nearest town)

50 yrs

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie M. Meredith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

J. Robert Meredith

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

Sept. 26, 1862

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace Wilmington, Delaware

(Town, county, and state)

10. Usual occupation School Teacher

11. Industry or business

12. Name John R. Padget13. Birthplace England14. Maiden name Anna Griffith15. Birthplace England16. Informant Robert WoodenAddress Woodensburg, Md.17. Burial Date thereof Sept. 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. GileadLocation Woodensburg, Md.18. Funeral director J. F. Eline, S.M.S.Address Reisterstown, Md.19. 9-27 1948
(Date rec'd by registrar)Mary B. Eline

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County Balto.City or town Woodensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 28

1948 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-7

1948

to 9-28 1948

and that I last saw her alive on

9-27

1948

Immediate cause of death

Hæmorrhage of left leg

DURATION

3 da.Due to arteriosclerosis3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None Date of

Where did injury occur?

(City or town)

(County)

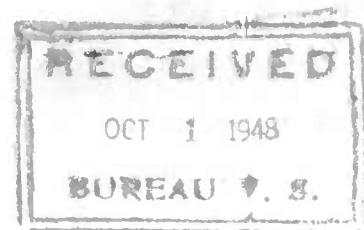
(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. D. Caples, M.D. M. D. or otherAddress Reisterstown, Md. Date signed 9-27-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

89193

CERTIFICATE OF DEATH

Reg. Dist. No. 53

1. PLACE OF DEATH:
County.....**Balto.**
City or town.....**Reisterstown**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....**1 yr.**

Hospital, institution, or street address where death occurred:
.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....**Md.** County.....**Balto.**
City or town.....**Reisterstown**
(If outside city or town limits, write RURAL and give nearest town)

Street No.....**Glenn Falls Road**
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
Robert Bennett Mimmack

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife.....**Mary A. Mimmack**

6.(c) If alive, give age.....years
7. Birth date of deceased (mo., day, yr.) **Feb. 1, 1860**

8. AGE: Years Months Days If less than one day
88 7 27 hrs. min.

9. Birthplace.....**Canada**
(Town, county, and state)

10. Usual occupation.....**Retired secretary**

11. Industry or business

MOTHER FATHER
12. Name.....**Joseph Mimmack**
13. Birthplace.....**England**

MOTHER
14. Maiden name.....**Frances Bennett**
15. Birthplace.....**England**

16. Informant.....**Mrs. Vena Welvaret**

Address.....**Reisterstown, Md.**

17. Burial.....**Riverside Cemetery**
(Burial, cremation, or removal. Which?) Date thereof.....**Oct. 1, 1948**
(month) (day) (year)

Cemetery or crematory.....**Rochester, N.Y.**

Location.....**J. F. Eline Sons**

18. Funeral director.....**Reisterstown, Md.**

Address.....**Mary B. Eline**

19. **9-27 1948**
(Date rec'd by registrar)

Registrar.....**John B. Eline**

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**Sept 27** 1948 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 27 1948 to Sept 27 1948,
and that I last saw him.....alive on Sept 27, 1948, alive

Immediate cause of death.....**Coronary artery Disease** DURATION **20 min.**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....**None** Date of.....

Where did injury occur?.....**None** (City or town).....**None** (County).....**None** (State).....**None**

Injured at home, farm, industry, public place (where?).....

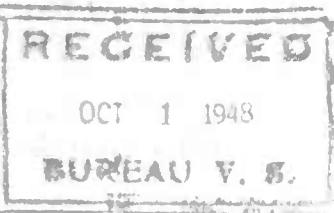
Means of injury.....

Injured at work?.....

23. SIGNATURE.....**A. D. Caples, M.D. exam** M. D. or other.....

Date signed.....**9-28-48**

Address.....**Reisterstown, Md.**



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09194
P.S.
44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 151 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or Institution?..... 151 Days

3. (a) FULL NAME

ERNEST ROBERT MOORE

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Married

6.(b) Name of ~~wife~~ wife..... Maurice Moore

7. Birth date of deceased (mo., day, yr.)

6-21-1907

6.(c) If alive, give age..... 42 years

8. AGE:

Years

Months

Days

If less than one day

41

3

7

....hrs.

....min.

9. Birthplace..... Waynesboro, Ga. (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... Unknown

13. Birthplace..... "

14. Maiden name..... Frances Colman

15. Birthplace..... Unknown

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 10/1/48

(month) (day) (year)

Cemetery or crematory..... Baltimore National Cemetery

Location..... Baltimore, Md.

18. Funeral director..... Charles R. Law

Address..... 802 Madison Avenue

19. Sept 30 48
(Date read by registrar)A.W. Hedrick
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1925 E. Chase Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-2

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 28, 1948, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1948, to September 28, 1948,

and that I last saw him alive on September 28, 1948.

Immediate cause of death.....

PULMONARY HEMORRHAGE

DURATION

36 hrs.

Due to..... Pulmonary Tuberculosis, bilateral, far advanced

7 mos.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

J. J. Anthony

Injured at work?

23. SIGNATURE..... J. J. Anthony, M.D.

M. D. or other

Address..... VAH. Fort Howard, Md. Date signed..... 9-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. 1 correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09195

93d

PC
Reg. Dist. No.

30

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Since May 8, 1945

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?

Since May 8, 1945

3. (a) FULL NAME

Anna Nuetzel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

Widowed

6. (b) Name of husband or wife

John Martin Nuetzel

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

July 31, 1883

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Kilomin Braeis

11. Industry or business

12. Name

Germany

13. Birthplace

Dorothy Herdt

14. Maiden name

Germany

15. Birthplace

Spring Grove State Hospital

Address

Calonesville, Md.

16. Informant

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Baltimore Cem.

Location

City

18. Funeral director

Jeffrick Funeral Home

Address

2008 Orleans St.

19. (Date rec'd by registrar)

9-8-48

19-

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County

City or town

Balto,

Street No.

807 N. Glencoe St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-7 1948 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death

Acute cardiac failure

Due to

Cardio vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

George Franklin Jefferson Ball Co.
M. D. or other
Address 1010 Leeds Ave
Date signed 9-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. If incorrect age is especially important, Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09196

53

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County..... Balto.
City or town..... Rockdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 11 years
Hospital, institution, or street address where death occurred:
Calvert Ave.
How long in hospital or institution?..... 11 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Md. State..... County..... Balto.
City or town..... Rockdale
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Calvert Ave.
(If rural, give LOCATION) NO
2.(a) Is veteran, name war.....

3. (a) FULL NAME

ANNA W. O'CONNOR

3. (b) Social Security Number
NO

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife..... Henry O'Connor

7. Birth date of deceased (mo., day, yr.)..... Feb. 7, 1867

8. AGE:	Years	Months	Days	It less than one day
	81	7	17	hrs. min.

9. Birthplace..... Troy, N. Y.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER FATHER
12. Name..... Richard Charlton
13. Birthplace..... unknown

MOTHER
14. Maiden name..... Phoebe A. Jacquet
15. Birthplace..... Pa.

16. Informant..... Mrs. Margaret J. Krug

Address..... Calvert Ave., Rockdale 7, Md.
17. Burial Date thereof..... 9/28/48
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Balto. Cem.
Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS
Address..... Balto., Md.

19. Date rec'd by registrar..... 9/25/48
Registrar..... *Tom E. Martin*

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 24, 1948, at 11:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1948 to Sept 24, 1948 and that I last saw her alive on Sept 23, 1948.

Immediate cause of death..... Carcinomatosis

Due to..... Carcinoma of nose

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *Tom E. Martin* M. D. or other

Address..... Randallstown Date signed 9/25/48



PLEASE WRITE PLAINLY, UPH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09197
38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10 Linden Terrace

How long in hospital or institution?

3. (a) FULL NAME

JULIA THERESA O'CONOR

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.)

October 20, 1869

6.(c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

78.

10

13

hrs.

min.

9. Birthplace

Texas, Balto Co., Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

MOTHER FATHER

12. Name

Hugh O'Conor

13. Birthplace

Maryland

14. Maiden name

Bridget Fahay

15. Birthplace

Ireland

16. Informant

Mrs. M. M. Watson

Address 10 LindenTerrace, Towson, Maryland

17. Burial

Date thereof Sept. 7, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St. Joseph's Cemetery

Location Texas, Balto Co., Maryland

18. Funeral director

John Burns Son

Address

Towson, Maryland

Decr 5 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 LindenTerrace

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3,

1948

at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 21 1942 to Sept. 3, 1948.

and that I last saw her alive on Aug. 31 1948.

Immediate cause of death Heart disease, sudden coronary with occlusion sudden

DURATION

sudden

Due to Heart disease chronic myopathy 10 yrs+

Due to

Other conditions Tuberculosis

Duration

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bolin B. Hudson MD

M. D. or other

Address Towson 4 Md Date signed 9/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09198
74a

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH: Baltimore County
County: *Baltimore Pt. Md.*
City or town: *Baltimore Pt. Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
Hospital, Institution, or street address where death occurred: _____
How long in hospital or institution? _____

3. (a) FULL NAME

4. Sex: Female | 5. Color or race: White | 6. (a) Single, married, widower, or divorced: Married
Name of husband or wife: Marion M Offley
7. Birth date of deceased (mo., day, yr.): Oct. 14. 1888
8. AGE: Years: 59 Months: 10 Days: 25 If less than one day: hrs: min:

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business: Clothing Wringard
12. Name: Arthur Wringard
13. Birthplace: Baltimore, Md.

MOTHER, FATHER: 14. Maiden name: Virginia Miller
15. Birthplace: Virginia

16. Informant: Marion M Offley

Address: 720 E. Pt. - Date thereof: 9-8-48
(Burial, cremation, or removal. When?)

Cemetery or crematory: Moreland Mem. Pt.
Location: Tanbark Lane

18. Funeral director: John C. Miller Son

Address: 2435 E. Oliver St.

19. (Date record by registrar): 9/10 1948 A.W. Hedrick
Registrar: 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: _____
City or town: *Baltimore Pt. Md.*
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 720 E. Pt. - Zip: 21202
(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-8-1948 at 10:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1948, to Sept. 8, 1948, and that I last saw her alive on Sept. 7, 1948.

Immediate cause of death: Chronic Lymphatic Leukemia
Duration: ± 5 years

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: *A. B. Janda, M.D.* M. D. or other

Date signed: 9-9-48
Address: 520 D St. Goldsboro, N.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09199

CERTIFICATE OF DEATH

Reg. Dist. No. 74a

38

1. PLACE OF DEATH:

County.....Baltimore
 City or town.....Hilfordale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joyce Ann Cussler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Singer

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 14 19458. AGE: Years Months Days If less than one day
3 3 15 hrs. min.9. Birthplace.....Baltimore Md
(Town, county, and state)10. Usual occupation.....Student

11. Industry or business.....

12. Name.....Rodger E. Cussler13. Birthplace.....Carroll Co Md14. Maiden name.....Ethel M. Armacost15. Birthplace.....Baltimore Co Md16. Informant.....Rodger E. CusslerAddress.....614 Wilton Road17. Burial.....Burial Date thereof.....10-3-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....St Paul'sLocation.....Upperco. Balt. Co. Md18. Funeral director.....John A. MoranAddress.....3000 E. Balt. St.19. Date rec'd by registrar.....Oct 1 194819. 48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....Baltimore
 City or town.....Hilfordale
(If outside city or town limits, write RURAL and give nearest town)
 Street No.....614 Wilton Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Sept 29 1948 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1948 to Sept 29 1948
and that I last saw her alive on Sept 29 1948

Immediate cause of death.....

Acute Leukemia

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....Lauree P. L. M. D.

M. D. or other

Address.....6805 York Rd Date signed.....9/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09200

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town

Baltimore

Cantonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

18 mo

Hospital, institution, or street address where death occurred:

St. Joseph's Hospital

How long in hospital or institution?

3. (a) FULL NAME

Florence M. Hally

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

Widowed

6. (b) Name of husband or wife

James W.

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Sept 9 1869

8. AGE:

Years

Months

Days

If less than one day
hrs. min.

9. Birthplace

10. Usual occupation.

Town, county, and state)

11. Industry or business

MOTHER FATHER

Hannay Hally

12. Name

Hannie Hallyton

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal? Which?)

Date thereof

(month day year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. 9-19 1948

(Date rec'd by registrar)

V. H. Harry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Baltimore

City or town

Essex (If outside city or town limits, write RURAL and give nearest town)

Street No

300 D Holly Drive (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18, 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1948, to Sept 18, 1948
and that I last saw her alive on Sept 15, 1948

Immediate cause of death

Acute Cardiac Failure 3 days

Due to

Cardio vascular disease 3 days

Due to

Senility 3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1010 Leed's Lane Date signed Sept 18, 1948

N
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS-AJ5 9-45-15M



PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09201

CERTIFICATE OF DEATH

Reg. Dist. No. 32

B3b

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 5 mos., 26 days

Hospital, institution, or street address where death occurred Mt. Wilson

Branch, Md. T.B. Sanatorium

How long in hospital or institution? 2 yrs., 5 mos., 26 days

3. (a) FULL NAME

Mrs. Mary Nueslein

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

James P. Nueslein

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

August 3, 1895

8. AGE:

Years
53Months
1Days
19

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name Joseph Kedzierski

13. Birthplace Poland

14. Maiden name

Augusta ?

15. Birthplace

Europe

16. Informant

Mrs. Mary Nueslein

17. Burial

Address 1531 Lancaster St., Balto., Md.

(Burial, cremation, or removal. Which?)

Date thereof Sept. 27, 1948
(month) (day) (year)

Cemetery or crematory

St. Stanislaus Cemetery

Location Mt. Carmel Rd., Balto., Md.

18. Funeral director Fred W. Ozazewski

Address 1930 Eastern Ave., Balto., Md.

19. Sept. 22, 1948

(Date rec'd by registrar)

Walter R. Hayes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1531 Lancaster Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 22,

1948 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27,

1946, to Sept. 22, 1948,

and that I last saw her alive on September 22, 1948,

Immediate cause of death

Pulmonary Tuberculosis

Due to Tubercle Bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings or operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

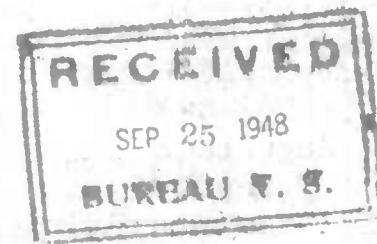
23. SIGNATURE

Stewart S. Shaffer M.D.

M. D. or other

Address Mt. Wilson, Md.

Date signed 9/22/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09202

40

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fullerton

(If outside city or town limits, write RURAL and give nearest town)

31 years

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Silver Lake Drive

How long in hospital or institution?.....

3. (a) FULL NAME

EPHRAIM EPHET PEYTON

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

male..... white..... married.....

6. (b) Name of husband or wife..... Mary F. Peyton

7. Birth date of deceased (mo., day, yr.)..... April 1867 6. (c) If alive, give age..... years

8. AGE: Year..... Months..... Days..... If less than one day
81..... hrs..... min.....

9. Birthplace..... Va. (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... James Peyton

13. Birthplace..... Va.

14. Maiden name..... Mahallie Lamb

15. Birthplace..... Va.

16. Informant..... Mrs. E. E. Peyton

Address..... Silver Lake Drive, Fullerton, Md.

17. Burial..... Date thereof..... Sept. 27, 1918
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Poplar Cemetery

Location..... Balt. Co., Md.

18. Funeral director..... Jascha's Funeral Home

Address..... 7401 Belair Road

19. (Date rec'd by registrar)..... 19.....

Harriet

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balt. a.

City or town..... Fullerton (If outside city or town limits, write RURAL and give nearest town)

Street No..... Silver Lake Drive (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 24th, 1918 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 10 1918 to Sept 22 1918 and that I last saw him alive on Sept 22 1918

Immediate cause of death.....

Chronic Cardiac decompensation

DURATION

years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

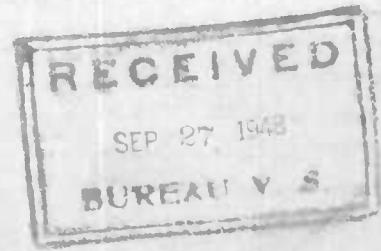
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Baldwin 9/26/48 Date signed.....





I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09203

CERTIFICATE OF DEATH

183

Reg. Dist. No.

44

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

9204 Riverdene Rd. Sykes Branch 383.

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

June 14 / 1946

8. AGE: Year

Months

Days

Less than one day

2 3 1 hr. min.

9. Birthplace

(Town, county, and state)

Balto. Md.

10. Usual occupation

None

11. Industry or business

Draf

tory

Ira Phelps

Balto. Md.

Helen Ulrich

Balto. Md.

Ira Phelps

Balto. Md.

9306 Bay Front Rd.

PLEASE WRITE PLAINLY, WITH UNDERRLING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09204

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 3D

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

June 5, 1948

Hospital, Institution or street address where death occurred:

Nursing Home, House at the Dunes

How long in hospital or institution?

1 yr. 4 mo.

3. (a) FULL NAME

William Quinby

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

Late Cecilia

7. Birth date of deceased (mo., day, yr.)

Dec 10th 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79 9 20 hrs. min.

9. Birthplace

Orange New Jersey

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

—

12. Name

Lyron Quinby

13. Birthplace

Orange 16

14. Maiden name

Mary Hull

15. Birthplace

Orange 16

16. Informant

Mr. Wickliffe C. Quinby

Address

5700 Blauregard Ave

17. Burial

Date thereof 10/4/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St Marks Cemetery

Location

W. Orange New Jersey

18. Funeral director

John J. Dowd & Son

Address

1103 Hollins Street

19. (If death by registrar)

9-30-48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md County.....

City or town.....

Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. #16

Fighting Ave (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 30th 1948, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 9, 1948 to Sept 30, 1948 and that I last saw him alive on Sept 29, 1948

Immediate cause of death

Myocardial Dystrophy

Due to Generalized arteriosclerosis

DURATION

2 yrs

1031 (3)

Due to

Other conditions Chronic Enteritis

1030 (3)

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Falloge M.D.

M. D. or other

Address Catonsville 28, Md. Date signed 9-30-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09206

CERTIFICATE OF DEATH

BC Reg. Dist. No. 30

✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County..... **Baltimore**
 City or town..... **Catonsville**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **4 Weeks**

Hospital, institution, or street address where death occurred:

..... **Haarlem Lodge**How long in hospital or institution?..... **4 weeks**3. (a) FULL NAME
Sallie Zea Ramey4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**6. (b) Name of husband or wife **Harry M. Ramey**7. Birth date of deceased (mo., day, yr.) **November 28, 1874**8. AGE: Years **73** Months **9** Days **12** If less than one day hrs. min.9. Birthplace..... **Strasburg, Va.**
 (Town, county, and state)10. Usual occupation..... **House-wife**11. Industry or business..... **Edward Zea**12. Name..... **Strasburg, Va.**13. Birthplace..... **Sarah William McCord**14. Maiden name..... **Strasburg, Va.**15. Birthplace..... **Edward Z. Ramey (Son)**16. Informant..... **3603 Gwynns Falls Parkway**

Address.....

17. Burial..... **9-11-48**
 (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory..... **Woodlawn**Location..... **Woodlawn, Md.**18. Funeral director..... **J. Howard Strong**Address..... **3207 W. North Ave.**19. Date record by registrar..... **9/10 48**

(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)County..... **Md.**
 City or town..... **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **2600 Lyndhurst Ave.**
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **September 9, 1948** **1.00**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **8/12** **1948** to **9/8** **1948**and that I last saw her alive on **9/8** **1948**Immediate cause of death..... **CARDIAC FAILURE** **DURATION** **12 HRS**Due to..... **HYPERTENSION** **?**Due to..... **CANCER, UTERUS** **?**Other conditions..... **CEREBRO-VASCULAR** **3 mos.****ACCIDENT (STROKE)**
 (Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **E.P. Williamson, M.D.** M. D. or other.....Address..... **3325 Frederick Rd.** Date signed..... **9/10/48**D.M. or other..... **30** Date signed..... **9/10/48**

I

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09207

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

29 Bloomsbury Ave., Catonsville

How long in hospital or institution?

3. (a) FULL NAME

Christopher Frederick Rappanier

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

malewhitewidowed

6. (b) Name of husband or wife

Virginia M. Rappanierdeceased

B. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Sept. 2, 1855

8. AGE:

Years
93

Months

Days

If less than one day

hrs. min.

9. Birthplace

Howard Co. Md.

(Town, county, and state)

10. Usual occupation

stone mason

11. Industry or business

self employed

MOTHER FATHER

Christian F. Rappanier

13. Birthplace

Germany

14. Maiden name

?

15. Birthplace

Germany

16. Informant

Frank O. Rappanier

Address

Catonsville 28 Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Sept 24, 1948

(month) (day) (year)

Cemetery or crematory

St. John's Cemetery

Location

Ellwood City, Md.

18. Funeral director

Edward J. Marable

Address

Catonsville, Md.

19. Date rec'd by registrar

9-23 1948

(Date rec'd by registrar)

H. Harvey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Balto.City or town Catonsville 28

(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Bloomsbury Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 21 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1945 to Sept 21 1948and that I last saw him alive on Sept 21 1948

Immediate cause of death

Coronary Thrombosis

DURATION

10 days

Due to

Arteriosclerized arteriesSclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

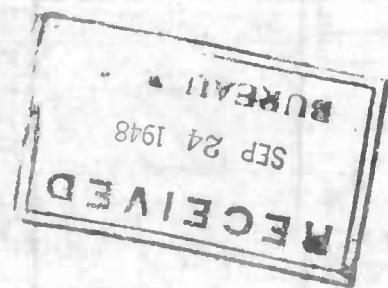
23. SIGNATURE

Deeves Stowell

M.D. or other

Address

Date signed 9-27



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Re
09208

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

I

1 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.
 2 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Since Jan. 27, 1947

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?..... Since Jan. 27, 1947

3. (a) FULL NAME

LEONARD CORBETT RIAL

4. Sex

M

5. Color or race

W. Separated

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Mary Anglum

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 18, 1898

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore City Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Joseph P RIAL

Baltimore Md.

13. Birthplace

Mary E Kinner

14. Maiden name

Baltimore Md.

15. Birthplace

Joseph P RIAL

16. Informant

Personal history-Hospital records

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9-15-48

(month) (day) (year)

Cemetery or crematory New Cathedral

Location Baltimore

18. Funeral director J. Luck

Address 5305 Harford Rd.

19. (Date recd by registrar) Sept 14, 1948 Q.W. Hegner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland Baltimore City

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2704 Gibbons Ave City 14

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1948, at 1:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27, 1947, to Sept. 13, 1948, and that I last saw him alive on September 13, 1948.

Immediate cause of death

Pulmonary tuberculosis

DURATION

Due to

Since about Jan 1948

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W.A. Bridges M. D. another

Address Tows. on 4, Md. Date signed 9-13-48

09211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? three months, twenty-four days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 months, 24 days

3. (a) FULL NAME

CAROLYN L. ROBERTS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

White

Widowed

6.(b) Name of husband or wife

Gus Smith

7. Birth date of deceased (mo. day, yr.)

December 28, 1877

6.(c) If alive give age years

8. AGE:

Years

Months

Days

If less than one day

70

8

10

hrs.

min.

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation..... housework

11. Industry or business..... Domestic

12. Name..... Alexander Roberts

13. Birthplace..... Baltimore

14. Maiden name..... Mary Ellen Monroe

15. Birthplace..... Baltimore

16. Informant..... Hospital records

Address..... Catonsville 28, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Sept. 10, 1948
(month) (day) (year)

Cemetery or crematory..... Mt. Carmel

Location..... Balto. Md.

18. Funeral director..... Philip Henry Sons,

Address..... 2024 Orleans St.

19. 9/7 1948 A.W. Hedrick
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Baltimore

City or town..... Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7409 Roberts Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 7, 1948, at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1948, to September 7, 1948,

and that I last saw her alive on September 7, 1948.

Immediate cause of death.....

Coronary thrombosis

DURATION

6 hours

Due to..... Arteriosclerosis, generalized
Hypertensive cardiovascular renal
disease

INDEFINITE

Due to.....

Other conditions..... Hemiplegia, left

1 month

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Isadore Tuerk, M.D.

M. D. or other

Address..... Catonsville 28, Md. Date signed 9/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

09212

CERTIFICATE OF DEATH

Reg. Dist. No.

H

1. PLACE OF DEATH:

County

BALTIMORE

City or town

DUNDALK - GRAY MANOR
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

GERTRUDE E. ROBERTS

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6. (b) Name of husband or wife

EDWARD ROBERTS

7. Birth date of deceased (mo., day, yr.)

JULY 17 1875

6. (c) If alive, give age.....years

8. AGE:

Year

Month

Day

If less than one day

73

1

25

hr.

min.

9. Birthplace

ROME NEW YORK

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

OWN HOME

MOTHER

FATHER

JOHN JONES

13. Birthplace

WALES

14. Maiden name

ELIZABETH RICHARDS

15. Birthplace

WALES

16. Informant

REGINALD B. ROBERTS

Address 8215 LONG POINT RD. DUNDALK

17. REMOVAL (Burial, cremation, or removal. Which?)

Date thereof 9/14/48

(month) (day) (year)

Cemetery or crematory

ROME

Location

ROME N.Y.

18. Funeral director

Wm Cook Esq.

Address

1217 ST Paul st

19. (Date rec'd by registrar)

9/13/48 At the Hospital

Dr. H. Hedrich

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH SEPTEMBER 12 1948 at 12⁰⁰ N

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JULY 28 1948 to SEPT 12 1948

and that I last saw her alive on SEPT 12, 1948

Immediate cause of death HEART FAILURE DURATION

Due to AURICULAR FIBRILLATION 1 DAY

Due to ARTERIOSCLEROTIC C. V. DISEASE - ?

PERNICIOUS ANEMIA 2 YR.

Other conditions MULTIPLE MYELOMA 1 YR.

SIMPLE FRACTURE RT. HIP 1 WEEK

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/2/48

Where did injury occur?

(City or town) County State

Injured at home, farm, industry or public place (where?) Home (City or town) County State

Means of injury (if applicable) Injured at work? (City or town) County State

23. SIGNATURE

Stephen C. Mackinlay M.D. M. D. or other

Address 6714 Holabird Ave Date signed 9/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

09213

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:			
(a) Baltimore City, Maryland			
(b) Street address		WILKINS AVE & KENWOOD	
(c) Hospital or institution:		BAUNIE VIEW HOME	
(d) Length of stay in hospital or inst. (yrs., mos., or days)			
(e) Length of stay in Baltimore (yrs., mos., or days)			
3 (a) FULL NAME		Mary N. Robesson	
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.	
F	W	WIDOWED	
6 (b) Name of husband or wife		NELSON O.	
6 (c) If alive, give age		D years	
7. Birth date of deceased (mo., day, yr)		12 - 10 - 1861	
8. AGE: Years		Months	Days
86		9	12
If less than one day		hr.	min.
9. Birthplace		MARYLAND (Town, county, and state)	
10. Usual Occupation		—	
11. Industry or business		—	
MOTHER FATHER	12. Name		JESSIE HALL
	13. Birthplace		MARYLAND
14. Maiden Name		—	
15. Birthplace		MARYLAND	
16 (a) Informant		MRS. SOMMERVILLE	
(b) Address		1803 WINANS AVE	
17 (a) BURIAL		(b) Date thereof 9/24/1948	
(Burial, cremation, or removal)		(month) (day) (year)	
(c) Cemetery or crematory		MT. OLIVER	
Location		FREDERICK RD	
18 (a) Funeral director		JOHN F. DENNY, INC.	
(b) Address		715 LIGHT ST - 30	
19 (a)		9/24/48 (b) A.C.W. Hedrick	
(Date record by registrar)		Registrar	

2. USUAL RESIDENCE OF DECEASED:

(a) State	MD	(b) County	Baltimore
(c) City or town		1803 WINANS AVE	
(If outside city or town limits, write RURAL and give town)			
(d) Street No.		HAZELTHORPE, MD	
(e) Citizen of foreign country?		(Yes or No)	
If yes, name country.....			

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/1948, at 12:45 M
21. I certify that death occurred on the date above stated, that I attended deceased from ~~Sept 21 1948~~ **and that I last saw him alive on** ~~Sept 21 1948~~

Immediate cause of death Acute coronary occlusion Duration 1da
 Due to coronary arteritis 2 yrs
General arteritis 4 yrs
 Due to generalized arteritis 5 yrs
senility 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
 (Specify type of place)

(e) Means of injury.

23. Signature A.C.W. Hedrick

M. D.

Address 1803 Winans Ave Date signed 9/24/48

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49214

38

CERTIFICATE OF DEATH

Bl
Reg. Dist. No.

1. PLACE OF DEATH: Baltimore

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armacost Nursing Home, 812 Register Ave.

How long in hospital or institution?

3. (a) FULL NAME

Suzanne H. Rose

4. Sex

Female

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife.....

late Charles B. Rose

7. Birth date of deceased (mo., day, yr.)

March 3, 1879

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

69 6

2

hrs.

min.

9. Birthplace.....

Balto. Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Henry Heath

12. Name.....

England

13. Birthplace.....

14. Maiden name.....

Sara Ann

15. Birthplace.....

England

16. Informant.....

C. Bennett Rose

Address

5809 Hillen Rd.

17. Mt. Olivet, burial

Date thereof.....

Sept. 7/48.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Olivet

Location

2930 Frederick Rd.

18. Funeral director.....

Address

Harry F. Witzel

4101 Edmondson Ave.

19. Date rec'd by registrar

20. Date of death

21. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

5809 Hillen Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 5/48.

19.

at 1545 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22, 1948, to Sept 5, 1948

19. 48

and that I last saw her alive on Sept 4, 1948

19. 48

Immediate cause of death.....

Cerebral Atherosclerosis

DURATION

5 yrs

Due to..... Sensility

5 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

None

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

A.S. Chaffard

M. D. or other

6210 York Rd. Date signed Sept 6, 1948

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, clearly and legibly write the causes of death.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09209
932

32

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Linens Road

How long in hospital or institution?

3. (a) FULL NAME

John Wilson Ruppert

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Hannah A. Ruppert

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

April 12, 1884

8. AGE:

Years	Months	Days	It less than one day
64	5	11	hrs. min.

9. Birthplace.....

Randallstown, Md.
(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business

12. Name..... William Ruppert

13. Birthplace..... Germany

14. Maiden name..... Mary C. Storkee

15. Birthplace..... Randallstown, Md.

16. Informant..... Mr. William Ruppert

Address..... 3612 Manchester St.

17. Burial..... Date thereof..... Sept. 25, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Mt. Olive Cemetery

Location..... Randallstown, Md.

18. Funeral director.....

Address..... 4510 Liberty Heights Ave

19. Date rec'd by registrar..... 9-24-48 Dr E E Nichols
Registrar..... Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No..... Linens Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-14-7908

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 23, 1948 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-23-1948 to 9-23-1948, 1948,

and that I last saw him alive on 9-23-1948 not seen alive 1948

Immediate cause of death.....

Arteriosclerotic C. - V. Disease 3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

NONE

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... NONE
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

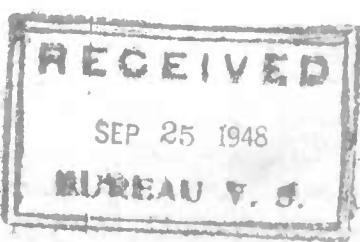
Means of injury.....

Injured at work?.....

23. SIGNATURE..... D. D. Caples, M.D. med. Exam.

M. D. or other

Address..... Reisterstown, Md. Date signed..... 9-23-1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09210

37

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH:

County

Baltimore

City or town

Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or Institution?

3. (a) FULL NAME

Benjamin L. Russell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widower

Katherine Russell

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Dec 29 - 1859

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Oyster packer

11. Industry or business

MOTHER FATHER

Josiah Russell

13. Birthplace

Virginia

14. Maiden name

Mary Hutchinson

15. Birthplace

Dent Ktne

16. Informant

L. M. Schroeder

Address

Masonic Home Cockeysville

17. Burial

Date thereof Sept 28-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Dund Cemetery

23

Location

Baltimore Md

18. Funeral director

Wm. A. Cook

Address

St. Paul & Preston St

19. 9/20

19 48

(Date rec'd by registrar)

L. M. Schroeder

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3024 Baber St

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 20

19 48 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

Aug 1 19 47 to Sept 20 19 48

and that I last saw him alive on Sept 20 19 48

Immediate cause of death

Heart Failure

DURATION

2 months

Due to

Arterio sclerosis

13 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

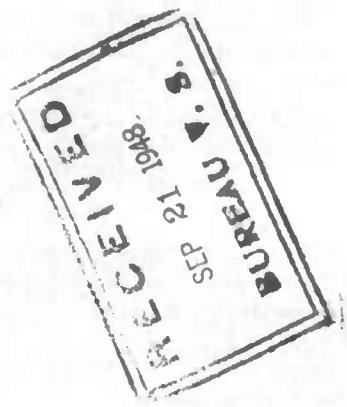
Means of injury

Injured at work?

23. SIGNATURE

Walter T. Kees M. D. or other

Address Cockeysville Md Date signed 9/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09215

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH:

County

Baltimore - 22

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

13 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Will Ryne (Rounds) (Rynes)

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elizabeth Rounds

7. Birth date of deceased (mo., day, yr.)

June 20, 1901

6. (c) If alive, give age

years

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09216

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town

Baltimore

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

35 yrs.

Hospital, Institution, or street address where death occurred:

129 Bloomsbury Ave

How long in hospital or institution?

3. (a) FULL NAME

Gideon N. Sauter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widower

6. (b) Name of husband or wife

Laura Edna

Sauter

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Feb. 13, 1888

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Woodlawn, Md.

(Town, county, and state)

10. Usual occupation

Plastering

Contractor

11. Industry or business

Charles C. Sauter

Charles C. Sauter

12. Name

Maryland

Maryland

13. Birthplace

Ella Stein

Ella Stein

14. Maiden name

Maryland

Maryland

15. Birthplace

Maryland

Maryland

16. Informant

F. Key Sauter

F. Key Sauter

Address

129 Bloomsbury Ave

129 Bloomsbury Ave

17. Burial

(Burial, cremation, or removal. Which?)

Sept. 10, 1948

Date thereof (month) (day) (year)

Cemetery or crematory

Lorraine Park Cem.

Lorraine Park Cem.

Location

Woodlawn, Md.

Woodlawn, Md.

18. Funeral director

Easton Sons

Easton Sons

Address

608 Frederick Ave. Catonsville

608 Frederick Ave. Catonsville

19. Date rec'd by registrar

9-9 1948

V.E. Harry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 Bloomsbury Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-28-6901

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 7, 1948 at 6²⁰A M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 6, 1948 to Sept. 7, 1948
and that I last saw him alive on Sept. 8, 1948

Immediate cause of death

Coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. J. Williamson, M.D.

M. D. or other

Address 4508 Edmonson Village Hills 29 Date signed Sept. 7, 1948

SEARCHED

SEP 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09217
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

Baltimore
County.Rossville, Rural-Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Ridge Road

How long in hospital or institution?

3. (a) FULL NAME

KATHERINE DOROTHY SCHEPF

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F. W Married

6.(b) Name of husband or wife Wm. Henry Schepf

7. Birth date of deceased (mo., day, yr.) April 7, 1882

8. AGE: Year Months Day If less than one day
63 5 18 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Daniel Malkus

13. Birthplace Maryland

14. Maiden name Margaret ?

15. Birthplace Maryland

16. Informant Mr. Wm. H. Schepf

Address Bx. 284 Ridge Rd. Baltimore -6

17. Burial Date thereof 9/29/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore cemetery

Location Baltimore, Maryland

18. Funeral director HENRY SANDER & SONS, INC.

Address NORTH AVE. & BROADWAY

19. Sept 28 1948 a.m. H. Schepf
(Date record by registrar) 88 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Rossville, Rural-Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box. 284 Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3, 1944, to Aug 20, 1944
and that I last saw her alive on Aug 20, 1944

Immediate cause of death

Cerebral Haemorrhage DURATION 1 hour

Due to Hypertensive Cardiovascular Disease DURATION 10 yrs?

Due to

Other condition General Arteriosclerosis DURATION 15 yrs?

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.H. Schepf M.D. or other

Address Ridge Rd. Baltimore -6 MD Date signed Sept 28 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09218
41

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Balto

City or town

Dundalk

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

6800 Martin Ave.

Stay in hospital or Inst. (yrs., or mos., or days)

12 yrs.

Stay in this community (yrs., or mos., or days)

12 yrs.

3. (a) FULL NAME

George Schaffer

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

M.

W.

Married

6 (b) Name of husband or wife

Minna Honberg

6(c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

7/18/65

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual occupation

Retired Brewer

11. Industry or business

Frank Schaffer

MOTHER FATHER

Germany

13. Birthplace

Germany

14. Maiden name

Anna Stiegel

15. Birthplace

Germany

16. Informant

Bertha A. Schaffer

Address

6800 Martin Ave

17. Burial

Date thereof

9/25/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Castor Ave Oct.

18. Funeral director

Lily & Zell Jr

Address

403 S. Wolfe St

19. Sept. 23 1948

William M. Kelly Jr.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balto

City or town

Dundalk

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

6800 Martin Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

No

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/22/1948, at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to Sept 22 1948 end that I last saw him alive on Sept 21 1948.

Immediate cause of death

G.I.-S-C-V-Rural Disease

Secondary

Gastritis

Gastritis & Carditis Disease

DURATION

10 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

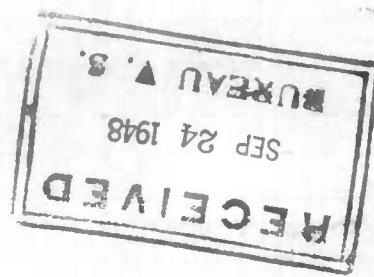
M. D. or other

Address

Dundalk

Date signed

Dr. Davis



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

89219

CERTIFICATE OF DEATH

B3d
B6
Reg. Dist. No.

1. PLACE OF DEATH:
County..... **Baltimore**

City or town..... **Baltimore - rural**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Armacost Nursing Home

How long in hospital or institution?

3. (a) FULL NAME
CECELIA ELIZABETH SCHLINGMAN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

8.(b) Name of husband or wife..... **Frederick Schlingman**

7. Birth date of deceased (mo., day, yr.) **June 29, 1878**

8. AGE: Year Months Days If less than one day
70 2 17 hrs. min.

9. Birthplace..... **BALTIMORE, MD.**
(Town, county, and state)

10. Usual occupation..... **At Home**

11. Industry or business

MOTHER FATHER
12. Name..... **Charles Ritz**
13. Birthplace..... **Berlin, Germany**

MOTHER
14. Maiden name..... ?
15. Birthplace..... **Funk**
Switzerland

16. Informant..... **Mrs. Marie Gaertner**
Address **1711 E. 31st. Street - 18**

17. Burial
(Burial, cremation, or removal. Which?) Date thereof..... **9/18/48**
(month) (day) (year)
Cemetery or crematory..... **Loudon Park Cemetery**

Location..... **Baltimore, Md.**
18. Funeral director..... **HENRY SANDER & SONS, INC.**
Address..... **NORTH AVE. & BROADWAY**

19. (Date rec'd by registrar) **9-18 1948** **A.W. Hadrich**
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... **Md.** County.....

City or town..... **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)

Street No..... **1711 E. 31st. Street**
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **September 15 1948** at **11.25 m** P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Aug 30** 1948 to **Sept 15** 1948 and that I last saw her alive on **Sept 15** 1948.

Immediate cause of death..... **Cerebral Hemorrhage** DURATION
3 days

Due to..... **Obst. peritonitis** Death **occurred** **3 yrs.**

Due to..... **Obst. peritonitis** **occurred** **3 days**

Other conditions..... **Obst. peritonitis** **occurred** **3 days**
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **I. W. Hadrich** M. D. or other

Date signed..... **9/16/48**

59

CERTIFICATE OF DEATH

Reg. Dist. No......

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		(For newborn infants, give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?..... Hospital, institution, or street address where death occurred:		Street No..... Address..... (If rural, give LOCATION)	
How long in hospital or institution?.....		2.(a) If veteran, name war..... No.	
3. (a) FULL NAME		3. (b) Social Security Number	
4. Sex..... Female		5. Color of race..... White	
6. (a) Single, married, widowed, or divorced Married		6. (c) If alive, give age..... 55 years	
6. (b) Name of husband or wife..... David Marshall Schroeder		7. Birth date of deceased (mo., day, yr.)..... Aug 1, 1899	
8. AGE: 49 Years		Months	Days
			It less than one day
			hrs.
			min.
9. Birthplace..... Baltimore, Md. (Town, county, and state)		10. Usual occupation..... Housewife	
11. Industry or business..... Own home		12. Name..... William Henry Rigley	
13. Birthplace..... Baltimore, Md.		14. Maiden name..... Clara Mullen	
15. Birthplace..... Baltimore, Md.		16. Informant..... David Marshall Schroeder	
17. Burial..... (Burial, cremation, or removal, which?) M. J. Oliver		Date thereof..... (month) (day) (year) 9/9/48	Autopsy results.....
Cemetery or crematory..... Gudrich, Md.		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Location..... 69 Fairington Ave		22. VIOLENCE: If death was due to external causes, fill in the following: None	
18. Funeral director..... A.W. Hedrick		Accident, suicide, or homicide.....	
Address..... 1938 E. Lafayette Ave		Where did injury occur?..... (City or town) (County) (State)	
19. (Date rec'd by registrar)..... 9/19/48		Injured at home, farm, industry, public place (where?).....	
X8		Means of injury..... Injured at work?	
Registrar..... A.W. Hedrick		23. SIGNATURE..... Rollin B. Hudson MD D.M.E.	
		M. D. or other	
		Address..... Towson, Md.	
		Date signed..... 9/6/48	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY;
UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09221

CERTIFICATE OF DEATH

Reg. Dist. No. *xx*

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 day

Hospital, institution, or street address where death occurred:

VAH FT. Howard, Md.

How long in hospital or institution?..... 1 day

3. (a) FULL NAME

HORACE SEDGWICK

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Col.	Married

6. (b) Name of husband or wife..... Ida Sedgwick

6. (c) If alive, give age..... 44 years

7. Birth date of deceased (mo. day, yr.)..... December 18, 1893

8. AGE: Years..... 54 Months..... 8 Days..... 16 Less than 60 day..... hrs..... min.....

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... farming

11. Industry or business.....

12. Name..... Horace Sedgwick

13. Birthplace..... Maryland

14. Maiden name..... Lizzie Arthur

15. Birthplace..... Maryland

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

17. Burial..... Cemetery or crematory..... Townsneck,

Location..... Arundel Co., Md.

Date interred..... September 19, 1948
(month) (day) (year)

18. Funeral director..... Joseph A. Lively

Address..... 661 W. Barre St., Baltimore, Md.

19. (Date record by registrar)..... 9/7 '48 A. W. Hedlund

Registrar..... D.M.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... A.A. Co.

City or town..... Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No..... ✓ (If rural, give LOCATION)

2.(a) If veteran, name war..... WW-1

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 4 1948 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 3, 1948 to Sept. 4, 1948 and that I last saw him alive on Sept. 4, 1948

Immediate cause of death.....

LOBAR PNEUMONIA

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results..... Substantiated Above Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. J. Rittmeyer, M.D. M. D. or other

Address..... VAH Fort Howard, Md. Date signed..... 9-1-48

PLEASE WRITE PLAINLY IN BLACK UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09222

38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: THE SHEPPARD AND ENOCH PRATT
HOSPITAL
BALTIMORE

County.....
City or town..... TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death..... 23 years, 3 mos., 15 days

Hospital, institution, or street address where death occurred:

The SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or Institution?..... 23 years, 3 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Illinois County..... Cook

City or town..... Chicago

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 111 West Monroe Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

SEGER, ALLISON

(Allison Tate Stewart Seger)

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widow

MEDICAL CERTIFICATION

6.(b) Name of husband or wife..... H. G. Seger, deceased

7. Birth date of deceased (mo., day, yr.) March 4 1859 6.(c) If alive, give age..... years
deceased (mo., day, yr.) unknown - said to be Mar. 4, 1860 or 1864

8. AGE: Years 89 Months 837 Days 6 If less than one day hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

MOTHER FATHER
12. Name..... Joseph Stewart

13. Birthplace..... Scotland

14. Maiden name..... Allison Rae (ALLISON RAE)

15. Birthplace..... Scotland

16. Informant..... HOSPITAL RECORDS also

Address..... Miss Mary Bell-Tudor Lewis-Bell

Burial Date thereof..... 9-11-48 (D)
(Burial, cremation, or removal. W/Mch?)

Cemetery or crematory..... Loudon Park

Location..... Baltimore

18. Funeral director..... Stewart Mortuaries

Address..... 108 West North Ave.

Sept 11 1948 (Date rec'd by registrar)

20. DATE OF DEATH September 10th 1948 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25th 1948 to Sept. 10th 1948

and that I last saw her alive on September 10th 1948

Immediate cause of death.....

Bronchopneumonia DURATION 2 da

Due to.....

Due to.....

Other conditions..... Senile Psychosis 25 yr

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

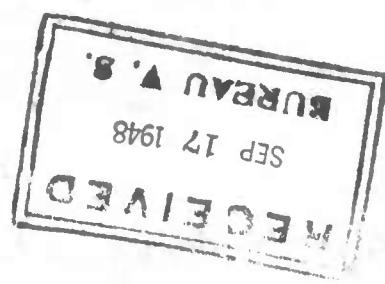
23. SIGNATURE..... M. Elgin, M.D.

Sheppard-Pratt Hospital

Address..... Towson 4, Md.

M. D. or other

Date signed..... Sept 10, 1948



09223

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If any item is especially important, physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15M

T VS A15

1. PLACE OF DEATH:
 County... Baltimore
 City or town... Fort Howard (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Alameda
 City or town... Baltimore (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1929 Wilkins Ave. (If rural, give LOCATION)
 2.(a) If veteran, name war... WWI

3.(a) FULL NAME

CHARLES E. SEWELL

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>MALE</u>	<u>White</u>	<u>Married</u>

6.(b) Name of husband or wife... Eunice Sewell

6.(c) If alive, give age... 40 years

7. Birth date of deceased (mo. day. yr.) 11-25-85

8. AGE: Years	Months	Days	If less than one day
<u>62</u>	<u>9</u>	<u>24</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace... Baltimore, Maryland (Town, county, and state)

10. Usual occupation... Sexton

11. Industry or business

12. Name... Joseph Sewell

13. Birthplace... Unknown

14. Maiden name... Mary ???

15. Birthplace... Baltimore, Maryland

16. Informant... Clinical Records, Vets. Adm. Hosp.

Address... Fort Howard, Md.

17. Burial... Loudon Ph- Date thereof... 9-27-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Baltimore - Mt

Location... Williams Cook - Mrs

18. Funeral director... Charles Sherrill

Address... 1717 St. Paul St.

19. Sept 20 1948 a.m. Howard (Date rec'd by registrar)

3.(b) Social Security Number
Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 19, 1948 st. 11:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18, 1948 to September 19, 1948 and that I last saw him alive on Sept. 19, 1948.

Immediate cause of death... CEREBRAL VASCULAR

HEMORRHAGE, WITH RIGHT

HEMIPLEGIA.

Due to...

Due to... Generalized arteriosclerosis

Other conditions... None

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Charles Sherrill, M.D. M.D. or other

Address... Ft. Howard, Md. Date signed Sept 19, 1948

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In
correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09224

95C

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph Howard Sheeler

4. Sex M W married
5. Color or race Single, married, widowed, or divorced

6. (b) Name of husband or wife.....
Mary Agnes Sheeler

7. Birth date of deceased (mo., day, yr.) *July 22, 1895*

8. AGE: Years 53 1 Months 1 Days 13 If less than one day hrs. min.

9. Birthplace *Ashland, Balt Co. Md.*
(Town, county, and state)

10. Usual occupation *Electrician*

11. Industry or business *Gas & Electric Co.*

12. Name *Howard Sheeler*

13. Birthplace *Cochranville, Balt Co. Md.*

14. Maiden name *Jessie Louise Johnson Smith*

15. Birthplace *Baltimore, Balt Co. Md.*

16. Informant *Mrs. Joseph H. Sheeler*

Address *Phoenix, Md.*

17. Burial Date thereof *9-7-48*
(Burial, cremation, or removal. Which?)

Cemetery or crematory *St. Johns Methodist*

Location *St. Johns, Md.*

18. Funeral director *Scott Brooks*

Address *Charles, Md.*

19. Date rec'd by registrar *9-7-48*

Wilmer C. Ensor

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*

City or town *Phoenix*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

212-07-6108

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sep 4 1948* at *105 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

home 19..... to 19.....

and that I last saw him *alive* on 19.....

Immediate cause of death *Heart disease, coronary occlusion*

DURATION *Sudden*

Due to *Chronic heart disease, type not determined*

Due to *.*

Other conditions *.*

(Include pregnancy within 3 months of death)

Major findings of operations *.*

Date of op. *.*

Autopsy results *.*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

No

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *.* Injured at work? _____

23. SIGNATURE *Bolling L. Hudson M.D. D.M.E.*

M. D. or other *.* Date signed *114/48*

Address *Towson Md.*



BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 63239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *4 Riverside Rd.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME *Philip E. Sides*

3 (b) If veteran, name war

4. Sex *M.*5. Color or race *W.*6 (a) Single, married, widowed, or divorced. *S.*6 (b) Name of husband or wife *[Redacted]*6 (c) If alive, give age *years*7. Birth date of deceased (mo., day, yr.) *6-10-47*8. AGE: Years *1* Months *3* Days *21* If less than one dayhr. *0* min. *0*9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name *David P. Sides*13. Birthplace *S.C.*

MOTHER

14. Maiden Name *Ethel Ethel*15. Birthplace *S.C.*16 (a) Informant *B.*(b) Address *Spokane*17 (a) *B.* (b) Date thereof *10-2-48*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *C. Lee*Location *Baltimore*18 (a) Funeral director *James H. Lutem*(b) Address *30 S. Latane*19. (a) Date rec'd by registrar *OCT 1 1948*

(b) Huntington Willing M.D.

(c) Register

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*(b) County *Baltimore*(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *4 Riverside Rd.*

(If rural give location)

(e) Citizen of foreign country? *No*
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/30 1948* at *7 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 20 1948* to *Sept 27 1948*, and that I last saw him alive on *Sept 27 1948*.

Immediate cause of death

*Bronchial pneumonia*Duration *Sept - 48*Due to *Metastatic carcinoma*

April - 1948

Due to *Malignancy of RT testicle*

JAN - 1948

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *when 6 months old*Major findings of operation *Malignancy of**RT testicle*

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence *at* *M.*(c) Where did injury occur? *(City or town) (County) (State)*

(d) Did injury occur about home, on farm, industrial place, in public

place? *While at work?*

(Specify type of place)

(e) Means of injury *Gash Lutem*23. Signature *James H. Lutem*Address *320 Patapsco Ave* M. D.Date signed *Oct 1 1948*

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

OCT 4 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09226

CERTIFICATE OF DEATH

44

Reg. Dist. No.

1. PLACE OF DEATH

County

Balto.

City or town

Middle River P.O.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eastern Ave.

How long in hospital or institution?

7 yrs.

3. (a) FULL NAME

John Silvers.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Caf. Widowed.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

about 1871

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

77

Martinsburg W. Va.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

W. Va.

14. Maiden name

Unknown

15. Birthplace

W. Va.

16. Informant

Joseph Armstrong

Address

Bengies Rd

17. Burial

Sharp St. Cemetery

(Burial, cremation, or removal Which?)

Cemetery or crematory

Bengies Md

Location

Potter Williams

18. Funeral director

Address

1515 McElderry St

Sept. 16, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 14 1948 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

and that I last saw him alive on

19.

Immediate cause of death

Coronary Arteriosclerosis

19.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Leorraine M.D.
Family Medical Doctor or other
Address: 1515 McElderry St
Balto. Date signed: Sept. 16, 1948

MARGIN RESERVED FOR BINDING

I

I

I

I

I

I

I

I

9-45-15 M

VS A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *Re*

2411 N. Charles St., Baltimore

97

09227
44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Baltimore - 22
Dundalk

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 weeks

Hospital, institution, or street address where death occurred:

8207 N Boundary Rd.

How long in hospital or institution?.....

3. (a) FULL NAME

Katherine Stepper

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Charles Stepper

80

7. Birth date of deceased (mo., day, yr.)

April 16. 1865.

6.(c) If alive, give age years

8. AGE:

Years

83.

Months

5

Days

5

If less than one day

hrs

min.

9. Birthplace.....

Charleston, S.C.

(Town, county, and state)

10. Usual occupation.....

Housework.

11. Industry or business

own home

MOTHER FATHER

12. Name.....

John Feldhausen

13. Birthplace.....

Germany

14. Maiden name.....

Anna Tellerberger

15. Birthplace.....

Germany

16. Informant.....

Carrie Riley.

Address

as in #1.

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Stephent's

Location.....

O'Donnell St

18. Funeral director.....

Lilly & Zeiler Ch.

Address

4031 S. Wolfe St

19. (Date rec'd by registrar)

9/22

1948

R.W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

80 W. Fleet St. Baltimore

Street No.....

2215 Fleet Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

X

MEDICAL CERTIFICATION

21. DATE OF DEATH

Sept. 20. 1948, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 10. 1948, to Sept. 20. 1948,

and that I last saw him alive on Sept. 20. 1948.

Immediate cause of death.....

Myocardial failure.
and pulmonary

Due to.....

oedema -

DURATION

2 days.

Other conditions.....

Atherosclerosis
Senility

10 yrs.

10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injury at work?

23. SIGNATURE

Louis M. Tollin, M.D.

6908 North St. Ed Baltimore, Md. Date signed

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09228

RIN No. G 117 SEP 21 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?

3. (a) FULL NAME

Therese Czeck

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced

Mariel

6.(b) Name of husband or wife

Jacob Czeck

6.(c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.)

10/15/82

8. AGE: Years 167 Months 65 Days / If less than one day / hrs. / min.

9. Birthplace Poland

(Town, county, and state)

10. Usual occupation

Housewoman

11. Industry or business

Daniel Huzcko

12. Name Daniel Huzcko

13. Birthplace Poland

14. Maiden name Catherine (?)

15. Birthplace Poland

16. Informant Mrs. Catherine Paskiewicz

Address 222 N. Chester St.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sep 14 1948

(month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Balt. City

18. Funeral director John J. Weber

Address 401 S. Chester St

19. 9/13 1948

(Date record by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1948 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/17 1947 to 9/10 1948

and that I last saw her alive on 9/10 1948

Immediate cause of death

Cardiac Failure

Due to Cachexia Bronchogenic carcinoma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mans of injury

Injured at work?

23. SIGNATURE

David J. Phillips, M.D.

M.D. or other

Address Spring Grove State Hosp Date signed 9/10/48

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09229

30

BC Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County **Baltimore**City or town **Catonsville**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **1 yr., 9 mos., 18 days.**

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? **1 yr., 9 mos., 18 days.**

3. (a) FULL NAME

M.

Elizabeth Starkey

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F**W****Divorced**

6.(b) Name of husband or wife

Vernon J. Starkey

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 10, 1894

8. AGE:

Years

Months

Days

If less than one day

54**1****29**

hrs.

min.

9. Birthplace

Maryland (Baltimore)

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Domestic

MOTHER FATHER

12. Name **Edward Heinze**

13. Birthplace

Maryland (Baltimore)

14. Maiden name

No Mary Schwinn

15. Birthplace

Maryland (Baltimore)

16. Informant

Hospital Records

Address

Catonsville-28, Maryland

17. Burial

Date thereof **9/11/48**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Baltimore

Location

Balto., Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19. (Date rec'd by registrar)

9-10 1948

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**

County

City or town **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **2029 E. 31st Street**

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 9**

19 48 at 8:45 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

November 22

19 46 to Sept. 9 19 48

and that I last saw her alive on **September 9** 19 48

Immediate cause of death

Coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Prefrontal lobotomyDate of op. **8-17-48**Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Isadore Tuerk, M.D.

M. D. or other

Address **Catonsville-28, Maryland** Date signed **Sept. 9, 1948**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.
Especially important. Physicians: Please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09230
572

CERTIFICATE OF DEATH

Reg. Distr. No. 32

1. PLACE OF DEATH:

County.....

City or town.....

Baltimore

Pikesville

(If outside city or town limits, write RURAL and give nearest town)

34

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Janie Patterson Stitt

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Nov 18 1913

6. (c) If alive, give age..... years

8. AGE: Years

34

Months

09

Days

25

If less than one day

hrs.

min.

9. Birthplace.....

Pikesville Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Herbert D. Stitt

12. Name.....

Herbert D. Stitt

13. Birthplace

Arkansas

14. Maiden name.....

Mary Pendleton

15. Birthplace

Baltimore Md

16. Informant.....

Mrs. Herbert D. Stitt

Address

Pikesville Md

17. Burial

Date thereof Sept 10/1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or -crematory.....

Dundridge

Location.....

Pikesville Md

18. Funeral director.....

Henry Winkins Sons Co

Address

4905 York Rd Baltimore

9-13-1948

(Date rec'd by registrar)

Dr E. Nichols

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Upland Rd

(If rural, give LOCATIONS) Sudbrook

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept 12 1948 at 2A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1934 to Sept 12 1948

and that I last saw h. b. alive on Sept 11 1948

Immediate cause of death.....

Retro pernicious tumor

not diagnosed.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Retro pernicious tumor

Date of op. Feb. 48.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Palmer P. Williamson M.D.

M. D. or other

Address..... Date signed Sept. 12.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09231

CERTIFICATE OF DEATH

Reg. Dist. No....

30

1. PLACE OF DEATH:

County.....

Baltimore
Lanhamville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 25 years or more.

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Grace E. Sullivan

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white

Married

6.(b) Name of husband or wife.....

William S. Sullivan

7. Birth date of deceased (mo., day, yr.)

February 5-1879

6.(c) If alive, give age ? years

8. AGE:

Years Months Days It less than one day

69

7

25

hrs.

min.

9. Birthplace

Towson, Bals. Co. Md

(Town, county, and state)

10. Usual occupation.....

Housewife

at Home

11. Industry or business

Edward Burnard

MOTHER FATHER

Maryland

14. Maiden name.....

Margaret Stone

15. Birthplace

Maryland

16. Informant.....

Mrs. William S. Sullivan

Address

Melvin Ave

17. Burial

Date thereof Oct. 2-1948

(Burial, cremation, or removal? Why?)

(month) (day) (year)

Cemetery or crematory

St. John's Cemetery

Location

Elliot City Howard Co Md

18. Funeral director

Geo. T. Boyer Jr

Address

1512 Hollins St Bals. Md

19. (Date rec'd by registrar)

19

G. W. Hedrich

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

Maryland Baltimore

City or town.....

Lanhamville Melvin Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 30 1948 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1946 to Sept 30 1948

and that I last saw h. alive on Sept 29 1948

Immediate cause of death Coronary Thrombosis

Due to Hypertensive Cardio. 6 yrs.

Disease

Due to

Other conditions Arterio. Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed

Dr. James S Howell
715 Benedict Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09232

BC Reg. Dist. No. 44

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Veterans Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 4 Days

3. (a) FULL NAME

CLARENCE W. THOMAS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife.....

Carrie Thomas

7. Birth date of deceased (mo. day, yr.)

3-30-92

8. (c) If alive, give age..... years

52

8. AGE:

Year

Month

Days

If less than one day

56

5

27

hrs.

min.

9. Birthplace.....

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

John W. Thomas

MOTHER FATHER

Maryland

14. Maiden name.....

Magdeline Fields

15. Birthplace.....

Eastern Shore, Md.

16. Informant.....

Clinical Records, Vets. Adm. Hosp.

Address

Fort Howard, Maryland

17. Burial.....

(Burial, cremation, or removal. Which?)

Bury thereon..... Oct. 2, 1948

(month) (day) (year)

Cemetery or crematory.....

Baltimore National Cemetery

Location.....

Baltimore, Maryland

18. Funeral director.....

Charles R. Law

Address

802 Madison Ave., Balto., Md.

19. (Date signed by registrar)

Sept 30, 1948

A. W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1823 Eagle Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 27,

1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above cited; that I attended deceased from

September 23, 1948 to September 27, 1948

and that I last saw him alive on September 27, 1948

Immediate cause of death.....

CARDIAC DILATATION AND HYPERTROPHY
WITH PULMONARY EDEMA

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury.....

Injured at work?

23. SIGNATURE..... A. C. Maneagh

H.C. MANAUGH, M.D. Chief Pro. Ser. for other

VAH, Ft. Howard, Md. Date signed 9-28-48

23
Galt
and
Main
St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09233
94a

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Balto.

City or town..... Ruxton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

OTTO R. THOMAS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

Iva Jenkins Thomas

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.) 6.(c) If alive, give age..... years

April 19, 1891

8. AGE: Years Months Days If less than one day hrs. min.

57 4 27

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation..... Co. Tax Office

Balto. Co.

11. Industry or business.....

12. Name..... Henry G. P. Thomas

13. Birthplace..... Germany

14. Maiden name..... Mary Parke

15. Birthplace..... Balto.

16. Informant..... Mrs. Iva J. Thomas

Address..... Ruxton, Md.

17. Burial Date thereof..... 9/20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Druid Ridge Cem.
Location..... Pikesville, Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

19. Date rec'd by registrar..... 9-18-48
(Date rec'd by registrar) 19.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

Ruxton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 16 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... 19..... 10..... 19.....

Immediate cause of death..... Heart disease,

coronary with occlusion-sudden.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Rollin L Hudson M.D. D.M.E.

M. D. or other

Address..... Towson Md. Date signed..... 9/16/48.

PLEASE WRITE PLAINLY, WITH UNDERRIDING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09234

CERTIFICATE OF DEATH

467
Reg. Dist. No. 37

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Caroline Tumbaugh

3. (b) Social Security Number

none

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Albert Tumbaugh6. (c) If alive, give age 58 yearsOct. 23, 1882

7. Birth date of deceased (mo., day, yr.)

Years 65 Months 10 Days 25 If less than one day

8. AGE:

Months 10 Days 25 If less than one day

9. Birthplace

Balto. Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name John W. Wolfe13. Birthplace Balto. Co. Md.14. Maiden name Elizabeth Busbee15. Birthplace Balto. Co. Md.

16. Informant

Albert TumbaughTowson

Address

17. Burial Burial Date thereof Sept. 20 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. JohnsLocation Sweet Air, Balt Co., Md.Random on Brooks

18. Funeral director

Address Sparks, Md.

Sept. 20, 48 Wilmer C. Ensor

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson (If outside city or town limits, write RURAL and give nearest town)Street No. Northwood Drive (If rural, give LOCATION)2.(a) If veteran, name war No

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 17 1946 to Sept. 17 1948and that I last saw her alive on Sept. 16 1948

Immediate cause of death

Heart Failure DURATION 10 days.Due to Rheumatic HeartMitral InsufficiencyFailureDue to Cancer of Pancreas

6 months

3 yrs. t

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

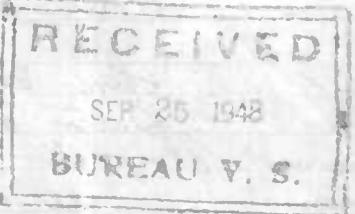
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. Donnell MD M. D. or other NoneAddress 301 York Rd Date signed Sept. 18, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Twin River Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Ernest Vesely

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 16, 1903

8. AGE: Years 45 Months 3 Days 16 If less than one day hrs. min.

9. Birthplace..... Czechoslovakia
(Town, county, and state)

10. Usual occupation..... Czechoslovak's helper

11. Industry or business

12. Name..... John

13. Birthplace..... Czechoslovakia

14. Maiden name..... Katherine Ludwig

15. Birthplace..... Czechoslovakia

16. Informant..... Mrs. Marie Langkam

Address..... 2601 Mura St.

17. Burial..... Date thereof..... 9/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oak Hill

Location..... Horner's Lane

18. Funeral director..... Clarence F. Hoffmann

Address..... 1639 N. Broadway

19. 9-3 48 Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore

City or town..... Twin River Beach
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-03-4710

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 1st 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19..... to..... 19.....

Immediate cause of death.....

Drowning

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of.....

Accident, suicide, or homicide.....

Where did injury occur?..... Twin River Beach, Md.

Injury (City or town) Gun Powder River (Copy) (State) Gun Powder River

Injured at home, farm, industry, public place (where?)

With whom young alone, went

Means of Injury (Name) Name failed to con (Injured at work?)

Signature..... M. Barlow MD

N.P. Medical Examiner, Baltimore, Md.

Address..... 11 Maryland Ave., Baltimore, Md. Date signed 9/1/48

~~The correct age~~
Evidence for change of
Birth date & age, shown on

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09236

FILM NO. G 117 OCT 7 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville Farms
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Viau

4. Sex 5. Color or race
Female White Widow

B.(b) Name of husband or wife Thomas Viau

7. Birth date of deceased (mo., day, yr.) May 22, 1880
6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
68 69 5 4 26 7 hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Joseph J. Cairns, Sr.

13. Birthplace Ireland

14. Maiden name Mary McCarron

15. Birthplace Ireland

16. Informant Louise Viau

Address Orchard Rd., Pikesville, Md.

17. Burial Date thereof Oct. 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18. Funeral director Frank H. Newell

Address Pikesville-8, Md.

19. 10/1 48
(Date rec'd by registrar) 837

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Pikesville Farms
(If outside city or town limits, write RURAL and give nearest town)
Street No. Orchard Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 29, 1948 at 11-PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1948, to Sept. 28, 1948

and that I last saw her alive on Sept. 28, 1948

Immediate cause of death Chronic Myocarditis

DURATION 2 yrs.

Due to Arterio Sclerosis

Due to

Other conditions Gall bladder disease

(probably gallstones)

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

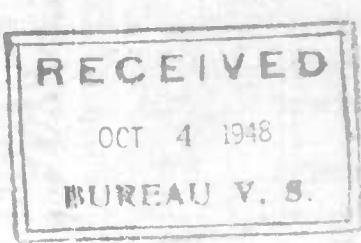
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. E. Dechale, M.D.
M. D. or other

Pikesville-8, Md. Date signed 10/1/48

Address



~~Please write plainly, with unfading ink.~~ Evidence for correction
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09237

41

CERTIFICATE OF DEATH

Reg. Dist. No.

FILM NO. G 117 OCT 13 1948

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore 22

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 min

Hospital, institution, or street address where death occurred:

910 Arondale Rd

How long in hospital or institution?

3. (a) FULL NAME

Mollie Halko

4. Sex

F

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

5/21/1906

6. (c) If alive, give age _____ years

8. AGE:

Years 50Months 42Days 18

If less than one day

hrs. 1min. 0

Dr. Hudson
606 Baltimore Ave.
Towson, 4, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09238

CERTIFICATE OF DEATH

38

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County..... Towson
City or town..... Baltimore Co.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
409 Delaware Avenue

How long in hospital or institution?

3. (a) FULL NAME

Edward Benedict Waller

4. Sex
male | 5. Color or race
white | 6. (a) Single, married, widowed, or divorced
divorced

6. (b) Name of husband or wife..... Grace

7. Birth date of
deceased (mo., day, yr.) Aug. 21, 19008. AGE: Years
48 Months
0 Days
21 If less than one day
..... hrs. min.9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business

12. Name..... Archibald Waller
13. Birthplace..... Md14. Maiden name..... Nellie E. Dashiell
15. Birthplace..... Md.16. Informant..... Mrs. Nellie E. Waller
Address 2823 Hemlock Avenue #1417. Burial..... Date thereof..... 9-15-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood Cem.

Location..... Baltimore, Md.

18. Funeral director..... Leonard J. Ruck
Address 5305 Harford Road #1419. (Date rec'd by registrar) Sept. 15 48 Auto. Reckless
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Towson

City or town..... Baltimore Co.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Delaware Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 11th, 1948, at 10 A.M. Approx.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on None

Immediate cause of death..... Heart disease, chronic

rheumatic with valvular involvement

Sudden failure on exertion

DURATION

Sudden

Due to.....

Due to.....

Other conditions..... Asthma, chronic

By no known

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. October 1/15/48

Address..... Towson Md. Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09239
136

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mos., 21 days

Hospital, institution, or street address where death occurred: Mt. Wilson

Branch, Md. T.B. Sanatorium

How long in hospital or institution? 1 yr., 11 mos., 21 days

3. (a) FULL NAME

John Nicholas Wathen

4. Sex

5. Color or race

Male

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

September 16, 1916

8. AGE: Years

Months

Days

If less than one day

32 0 4

hrs.

min.

9. Birthplace..... Washington, D. C.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

MOTHER FATHER

12. Name..... John Wathen

13. Birthplace..... Newport, Maryland

14. Maiden name..... Frances Stonestreet

15. Birthplace..... Gallent Green, Maryland

16. Informant..... John Nicholas Wathen

Address..... Newport, Chas. Co., Md.

17. Burial..... Date thereof..... Sept. 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Mary's Cemetery

Location..... Newport, Chas. Co., Maryland

18. Funeral director..... Hunt & Ryan

Address..... Waldorf, Maryland

19. Sept. 20, 1948
(Date rec'd by registrar) Helen R. Mayo
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Charles Co.

City or town..... Newport
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Sept. 20, 1948, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 30, 1946, to Sept. 20, 1948

and that I last saw him alive on Sept. 20, 1948.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

6 yrs.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... None

(Include pregnancy within 3 months of death)

Major findings of operations..... No operation

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

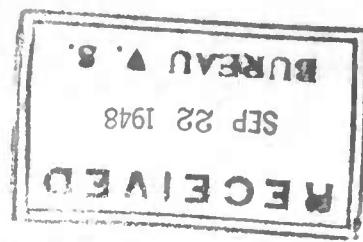
Means of injury.....

Injured at work?

23. SIGNATURE.....

Stewart S Shaffer M.D.
M. D. or other

Address..... Mt. Wilson, Md. Date signed 9/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09240

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 0 yrs., 1 mo., 14 daysHospital, Institution, or street address where death occurred: Mt. WilsonBranch, Md.T.B.SanatoriumHow long in hospital or institution?..... 0 yrs., 1 mos., 14 days

3. (a) FULL NAME

Joseph R. Weaver

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Doris Weaver

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 21, 1920

8. AGE:

Years

Months

Days

If less than one day

28

6

5

.....hrs.min.

9. Birthplace.....

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

Clerk

11. Industry or business

MOTHER FATHER

12. Name.....

Francis Weaver

13. Birthplace.....

Seattle, Washington

MOTHER FATHER

14. Maiden name.....

Josephine Weaver

15. Birthplace.....

Baltimore, Maryland

16. Informant.....

Joseph R. Weaver

Address.....

218 S. Payson St., Balto., Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... Sept. 29, 1948

(month) (day) (year)

Cemetery or crematory.....

Baltimore National Cemetery

Location.....

5501 Fred. Ave., Balto., Md.

18. Funeral director.....

John J. Cowan & Sons

Address.....

901 Hollins St., Balto., Md.

19. Sept. 26, 1948

(Date rec'd by registrar)

Joseph R. Weaver

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 218 S. Payson Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War II

3. (b) Social Security Number

212-12-5748

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 26, 1948

2:25 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from August 12, 1948 to Sept. 26, 1948 and that I last saw h. im. alive on Sept. 26, 1948.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

6 mos.Due to..... Tubercle Bacilli

Due to.....

Other conditions..... None

(Include pregnancy within 3 months of death)

Major findings of operations..... No operation.

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE Stewart S Shaffer M.D.

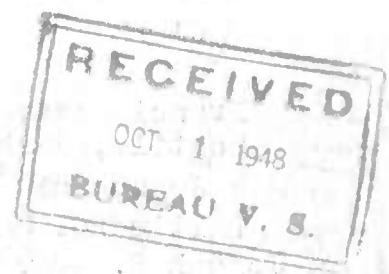
M. D. or other

Address..... Mt. Wilson, Md.Date signed 9/26/48PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check correct age
is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09241

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

1 yr.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Julien Joseph Welvaert

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife

Celine Reiss Welvaert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 3, 1871

8. AGE:

Years
77Months
2Days
19

If less than one day

hrs.

min.

9. Birthplace

Belgium

(Town, county, and state)

10. Usual occupation

Architect

11. Industry or business

MOTHER FATHER

12. Name Joseph Welvaert

13. Birthplace

Belgium

14. Maiden name

Justine Mattele

15. Birthplace

France

16. Informant

Albert T. Welvaert

Address

Reisterstown, Md.

17. Burial

Date thereof Sept. 25, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

All Saints

Location

Balto. C.C.

18. Funeral director

J. F. Eline, Sons

Address

Reisterstown, Md.

19. 9-24

19. 48

Mary B. Eline

Registrar

(Date rec'd by registrar)

97

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Glenn Falls Road

(If rural, give LOCATION)

2.(a) If veteran, name war.

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 22

19. 48 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-17

19. 48

to 9-22

19. 48

and that I last saw him alive on 9-21

19. 48

Immediate cause of death

arteriosclerotic gangrene
of Rt. Foot.

DURATION

10 da.

Due to

atrioventricular

2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. D. Caplis, M.D.

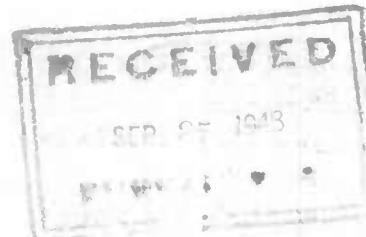
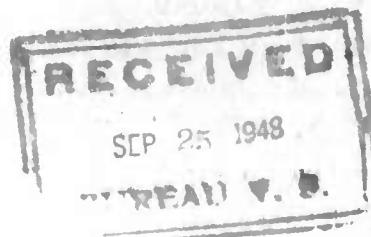
M. D. or other

Address

Reisterstown, Md.

Date signed

9-24-48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09242

CERTIFICATE OF DEATH

BC Reg. Dist. No. 44

1. PLACE OF DEATH:

County... Baltimore

City or town... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.

How long in hospital or institution? 8 days

3. (a) FULL NAME

EDWARD WEST

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Married

6.(b) Name of husband or wife Mary West

7. Birth date of deceased (mo., day, yr.) March 9, 1865 6.(c) If alive, give age 49 years

8. AGE: Years Months Days If less than one day
83 6 5 hrs. min.9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name William

13. Birthplace Virginia

14. Maiden name Unknown

15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof 9-20-48
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Charles R. Law

Address 802 Madison Ave., Balto., Md.

19. Sept 17 1948 A. W. Herrick
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4614 Falls Road

(If rural, give LOCATION)

2.(a) If veteran, name war P. I.

3. (b) Social Security Number
Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1948, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6, 1948, to September 11, 1948,

and that I last saw him alive on September 11, 1948.

Immediate cause of death Carcinoma of lungs
with metastasisDURATION
3 mos +

Due to:

Due to:

Hydrothorax and Heart
Failure
(Include pregnancy within 3 months of death)

2 wks

Major findings of operations.

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milton Ginsberg M.D.
Address VAR. Fort Howard, Md. M. D. or other
Date signed 9/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09243
175e1

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

22 Days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Maryland

22 Days

How long in hospital or institution?

3. (a) FULL NAME

LAWRENCE A. WEST

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Divorced

6.(b) Name of husband or wife

8.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

10-28-11

8. AGE:

Years

Months

Days

If less than one day

36

10

20

hrs.

min.

9. Birthplace..... Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Manager Store

11. Industry or business

12. Name..... George West

13. Birthplace..... Maryland

14. Maiden name..... Unknown

15. Birthplace..... Maryland

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Where?)

Date thereof..... Sept 22, 1948
(Month) (Day) (Year)

Cemetery or crematory..... Baltimore National

Location..... Baltimore, Md.

18. Funeral director..... Charles F. Law

Address..... 802 Madison Avenue

19. 9/20 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Baltimore

City or town..... Baltimore (Dundalk)

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 330 Flicker Court

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-II

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 18, 1948 at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1948 to September 18, 1948 and that I last saw him alive on September 18, 1948.

Immediate cause of death..... RUPTURE OF LEFT KIDNEY, SPONTANEOUS; HUGE RETROPERITONEAL HEMATOMA

DURATION

12 hrs.

Due to.....

Due to..... Thrombosed Vein

Other conditions..... Acute Pyelonephritis

12 hrs.

Unknown

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur.....

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... H.B. Chapman, M.D.

M. D. or other

Address..... Ft. Howard, Md.

Date signed..... 9-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09244
838

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Mt. Royal

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Percy Williams

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age..... years

Mar 27 - 1868

8. AGE:

Years

Months

Days

If less than one day

*80**5**-**hrs.**min.*

9. Birthplace.....

(Town, county, and state)

Baltimore Md.

10. Usual occupation.....

Cv. manger

11. Industry or business.....

Augusta Williams

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

Date signed.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

*Md.**Baltimore*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept 17 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 2 1947 Sept 17 1948*and that I last saw him alive on *Sept 16 1948*

Immediate cause of death.....

Cerebral Thrombosis 7 da.

Due to.....

General Arteriosclerosis 5 yrs.

Due to.....

DURANON

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other.....

Address..... Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09245

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH:

County

Baltimore

City or town

Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 yrs

Hospital, Institution, or street address where death occurred:

Masonic Home, Cockeysville Md.

How long in hospital or institution?

3. (a) FULL NAME

Mary J. S. Wootten

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Charles Edward Wootten

7. Birth date of deceased (mo. day, yr.)

Jan. 15 - 1868

8. AGE:

Years
80Months
8Days
7If less than one day
hrs. min.

9. Birthplace

Belvoir Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Judge Wm. H. Seth

12. Name

Mother FATHER

13. Birthplace

Belvoir Md.

14. Maiden name

Sarah Eleanor Hopkins

15. Birthplace

Trappe, Md.

16. Informant

Laura M. Schaefer

Address

Masonic Hospital, Cockeysville

17. Burial

Date thereof Sept. 25, 48
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Woodlawn

Location

Baltimore

18. Funeral director

Wm. Cooke

Address

St. Paul & Preston St

19. Date rec'd by registrar

Sept. 23, 48

(Date rec'd by registrar)

of M. Schaefer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2206 Roslyn Ave Baltimore

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22

1948 at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec.

19

to Sept. 22 1948

and that I last saw her alive on Sept. 22 1948

Immediate cause of death

Coronary Thrombosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter T. Keo M.D.

M. D. or other

Address Cockeysville Md. Date signed 9/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09246

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County.....

Baltimore
Dundalk

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

7022 Dundalk Road

How long in hospital or institution?.....

3. (a) FULL NAME

Ruth W. Yeager

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

m.

Harry J. Yeager

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

43

Months

11

Days

25

If less than one day

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

Carroll Co., Md.

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date of death.....

(Date rec'd by registrar)

Wm. A. Le Brun

Baltimore, Md.

Mellie Smith

Carroll Co., Md.

Harry J. Yeager

7022 Dundalk Road, Dundalk

Burial

Date thereof Sept. 19, 1948

(month) (day) (year)

Shiloh

Hampstead, Carroll Co., Md.

Roland L. Fisher

2112 Dundalk Ave., Dundalk, Md.

Sept. 18, 1948 William M. Kelly Jr.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

Dundalk

Street No.

7022 Dundalk Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 16th 1948 av 10⁴⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 38 1948 to Sept. 15 1948 and that I last saw him alive on Sept. 15 1948

Immediate cause of death

Br - latrine pulmonary

Tuberculosis

Due to

DURATION

52 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Nose

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

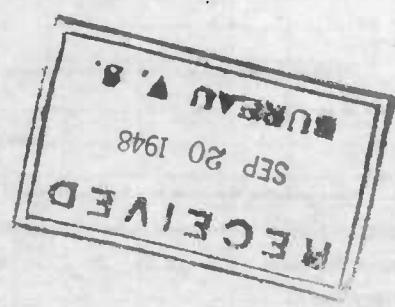
23. SIGNATURE

J. B. Davis M.D.

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09247

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

Baltimore

County

Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 6 mos., 3 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T.B. Sanatorium

How long in hospital or institution? 0 yrs., 6 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2016 Penrose Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

216-05-0652

3. (a) FULL NAME

Harry E. Young

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Claudia C. Young

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) March 23, 1911

8. AGE: Years	Months	Days	If less than one day
37	5	19	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

MOTHER FATHER
12. Name Harry Pohlmann Young
13. Birthplace Baltimore, Md.

MOTHER FATHER
14. Maiden name Carrie Fultz
15. Birthplace Elkton, Mirginia

16. Informant Harry E. Young

Address 2016 Penrose Ave., Balto., Md.

17. Burial Date thereof Sept. 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Louden Park Cemetery

Location Baltimore, Maryland

18. Funeral director Geo. L. Beyer, Jr.

Address 1512 Hollins St., Balto., Md.

19. 9/11/48
(Date rec'd by registrar) 19.....Aber R. Mayer
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 11, 1948 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1948, to Sept. 11, 1948, and that I last saw him alive on Sept. 11, 1948,

Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Larynx DURATION 3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S Shaffer m.D. M. D. or other

Address Mt. Wilson, Md. Date signed 9/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

09248

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

1726 Tees Oaks Rd - B27

Stay in hospital or Inst. (yrs., or mos., or days)

5 yrs

Stay in this community (yrs., or mos., or days)

5 yrs

3. (a) FULL NAME

Mrs Robt. R. Young his wife (-GERTRUDE)

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Robt. R.

7. Birth date of deceased (mo., day, yr.)

May 15 - 1902

8. AGE:

Years

Months

Days

If less than one day

46

4

16

hrs. ✓

min.

9. Birthplace Derby England

(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Arthur St. Dunn

13. Birthplace England

14. Maiden name Sarah N. GREEN

15. Birthplace England

16. Informant Strahorn

Address 1726 Tees Oaks Rd.

17. BURIAL Cemetery or crematory

Date thereof SEPT. 20 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory MT OLIVET

Location

FREDERICK AVE

18. Funeral director Harry H. Witzke

Address 4101 Edmondson Ave

19. Sept 18 1948 Death certificate

(Date rec'd by registrar)

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Baltimore

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Ward No.

Street No. 1726 Tees Oaks Rd 27

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18

1948, at 4A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1943 to Sept 18 1948

and that I last saw her alive on Sept 16

1948

Immediate cause of death

Carcinoma Bl. breast

DURATION

5+ yrs

Due to wrote generalized metastasis

Due to cachexia

3+ yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Carcinoma

Of operations

Of autopsy

✓

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Frederic V. Beeler

M. D. or other

Address 713 Mechanical Arts Bldg

Date signed 9-18-48

Mr.
Balderson → ↘
call later

ark 214 - Poffen

